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REPORT
No. 92-46

DEVELOPMENTS IN AGING
1970

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 316, FEBRUARY 16, 1970

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

TOGETHER WITH

MINORITY VIEWS

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[1] Senator Williams was chairman of the committee until elected chairman of Labor and Public Welfare Committee on Jan. 28, 1971. Senator Church was appointed chairman of the Special Committee on Aging on Jan. 29, 1971.

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LETTER OF TRANSMITTAL

MARCH 18, 1971.

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

DEAR MR. PRESIDENT: As required under Senate Resolution 316, adopted February 16, 1970, I am submitting to you the report of the Special Committee on Aging.

This report takes on special significance in 1971, a year which will culminate with a White House Conference on Aging. For that reason, the committee—in addition to presenting information on its studies and work activities during the past year—also summarizes progress made since the White House Conference on Aging of 1961 and suggests issues that should receive careful consideration before, during, and after the 1971 White House Conference on Aging.

Senate Resolution 27, which was passed unanimously by the Senate on March 1, 1971, 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,

FRANK CHURCH, *Chairman.*

SENATE RESOLUTION 316, 91ST CONGRESS, 2D SESSION

Resolved, That the Special Committee on Aging, established by S. Res. 33, Eighty-seventh Congress, agreed to on February 13, 1961, as amended and supplemented, is hereby extended through January 31, 1971.

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, 1970, through January 31, 1971, 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 $2,700 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 $215,000 from February 1, 1970, through January 31, 1971, 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, 1971. The committee shall cease to exist at the close of business on January 31, 1971.

PREFACE

A Message to All Who Participate at the White House Conference on Aging and in Preliminary Activities

> "In spite of the many surveys, books, and conferences on aging, the greatest accomplishment to date has been the output of words."
>
> —The Honorable John E. Fogarty, U.S. House of Representatives, January 8, 1958 (in introducing H.R. 9822, calling for a White House Conference on Aging in 1961).

Representative Fogarty, when he made the comments excerpted above, perhaps had more reason for impatience than do present Members of Congress.

Today, after all, we have made considerable progress since the 1961 White House Conference on Aging. Congress has enacted Medicare, Medicaid, some Social Security improvements, widely-varying housing programs, promising new pilot programs for employment for men and women past age 55, the Age Discrimination in Employment Act, and a few grant programs which offer services to the elderly.

Nevertheless, as this Nation approaches another White House Conference on Aging, we must ask ourselves the question suggested by the late Mr. Fogarty's comment:

> Will conferees merely contribute to the output of words, or will they shape a genuine strategy for action on clearcut goals during the next decade?

Congress has a direct interest in the answer to that question, and the Senate Special Committee on Aging has special reasons for wanting the answer to be the right one.

It was through legislation originated by individual members of this Committee that the authority for the Conference was granted. The Committee, fully in support of the Conference, has dedicated much of its work since September 28, 1968—when the bill [1] was signed—to obtain and to present facts that should receive careful attention before and during the conference.

Thus, late last year, the Committee concluded 2 years of hearings and task force activity with publication of a report on the "Economics of Aging: Toward a Full Share in Abundance."

A report on "Old Americans and Transportation: A Crisis in Mobility," was also published; it told of a problem which has become one of the most crucial now facing aged and aging individuals.

[1] P.L. 90–526.

In these final months before the White House Conference, the Committee will continue to issue reports on subjects of direct importance to older Americans, such as: unique problems of minority groups, the elderly in rural areas, usefulness of the model cities program to older Americans, alternatives to institutionalization in State hospitals, trends in long-term care, opportunities for nonprofit sponsors to assist in government programs, and housing needs.

Our purpose, of course, is not to instruct, or even to appear to instruct, the conferees. We recognize that Conference activities are subject to many inputs: from the Administration on Aging and other units of the Executive Branch, from national organizations, from State offices on aging, from the elderly who have already spoken out at community forums and who will speak out at later events, from technical committees, and many more sources.

But Congress must make an input, too. It must put into as sharp a focus as possible its view of the progress, or lack of progress, made thus far through legislation. It must also express, in some way, suggestions for additional action that will contribute to a working national policy on aging.

In the report which follows, the Congressional Committee assigned by the Senate to keep abreast of developments and legislative opportunities related to aging makes one contribution to the Congressional input. Each chapter, in addition to describing events that transpired in 1970, also summarizes issues and recommendations as seen in 1961—recommendations, incidentally, which were never translated into the "blueprint for action" so often requested by Representative Fogarty and others. In this way, the Committee is attempting to fulfill its obligation to the Senate and to the public during this White House Conference year.

In addition, I am including, in this preface, the following questions which may merit the attention of those who participate not only in the Conference itself, but in the preliminary intra-State and State conferences planned for this spring, to those task forces that will analyze the recommendations emanating from the States, and to those who are directing all of these functions:

ONE.—As now designed, the Conference plan lays great stress upon *reducing* the number of final policy recommendations to a limited, manageable few. This is a laudable objective, but there may be some danger that in "priority-setting" the conferees will be led to make arbitrary and perhaps meaningless choices. Instead of synthesizing, they could tend merely to sift.

If—as has been said so often within recent months—the goal of the Conference is to develop a national policy on aging, shouldn't the directors of the Conference make a greater effort to produce mechanisms which will promote cohesion and depth in final decisions of the conferees? Unrelated or conflicting recommendations, however limited in number, would produce not a policy, but a new sampling of limited objectives.

TWO.—Closely related is the growing concern about the adequacy of pre-White House Conference assembling of "hard facts" which represent present knowledge about aging. In its report on the "Economics of Aging," for example, this Committee asserted that the conferees might easily become deadlocked about a

vital issue—the contribution that private pensions can make to retirement security [2]—unless more facts are rooted out between now and November. The report suggested that task forces of experts from various disciplines immediately be convened—without regard to political affiliation—to define the reasonable limitations of future retirement income from private pension plans. The report on Transportation and the Elderly made similar recommendations for multi-agency cooperation in certain fact-finding missions.[3]

Unless the directors of the Conference make all possible efforts to assemble readily obtainable information *in advance* of the Conference, we can be almost certain that needless argument or confusion will result.

For this reason, it is deeply disturbing that Technical Review Committees—established to analyze and improve technical papers prepared by knowledgeable authors—are now months behind in progress toward previously announced goals. It is even more disturbing that political considerations are said to have had an influence upon the selection of members of those committees.

THREE.—There is a danger that the Conference could be unduly swayed by attempts to shape allegiance to an "income strategy" to the exclusion of a "service strategy." The case for the income strategy has been advanced by former Presidential advisor Daniel Moynihan and others, and at first glance it seems persuasive when it argues:

> The way to help people to the services they need is not for government to provide the services, but to help them have sufficient income to purchase the services of their choice.

But as is so often the case, it's not a simple "either-or" proposition. Older Americans certainly *must* have major advances in retirement income. But their need for services is great and in some cases may be even more acute than the need for dollars. If a semidisabled widow, for example, can't find a homemaker to perform essential chores for her, she may become institutionalized. Lack of transportation, particularly for those in rural areas, can and does cause bitter isolation. Quite often, the lack of a less expensive kind of service—such as regular health checkups—can lead to more expensive alternatives, such as hospitalization.

FOUR.—The Conference will take place at a time when debate may be fiercely intense on two concepts which have become the heart of President Nixon's domestic program. They are revenue sharing and sweeping governmental reorganization.

Revenue Sharing.—Walter Heller first advanced this concept 7 years ago while serving as Chairman of the Council of Economic Advisors. He and others, however, see revenue sharing as one component in a more general program intended to rearrange financing responsibilities among Federal, State, and local governments. The Advisory Commission on Intergovernmental Relations, for example, in December, 1970, called for revenue sharing

[2] Economics of Aging: Toward a Full Share in Abundance, Report No. 91–1548, pp. 5–6.
[3] Older Americans and Transportation: A Crisis in Mobility, Report No. 91–1520, pp. 55–57.

as merely one part of a package which would also include: Assumption by the Federal Government of all costs of public welfare and Medicaid; assumption by State governments of substantially all local costs of elementary and secondary education; encouragement of a high-quality, high-yield State tax system through a Federal income tax credit for State income taxes paid; and creation of a more manageable and streamlined categorical aid system through consolidation and joint funding of existing Federal grant programs.

The Advisory Commission recommendations are mentioned in this preface to illustrate the complexities involved in the practical application of revenue sharing. Any attempt by the White House conferees to solve the knotty problems related to revenue sharing as a means of increasing funds available for programs meant to serve older Americans would almost certainly be foredoomed, though the temptation to engage in such speculation may well be strong.

Executive Branch Reoragnization.—Much the same is true of President Nixon's proposals for reorganization of the Executive Branch. The Intergovernmental Advisory Commission says that the 500 existing categorical grant programs comprise a bewildering proliferation. But even while calling for efforts to give States and municipal governments more flexibility in meeting their needs, the Commission says that, where appropriate, Federal *consolidation* should take place; i.e. federalization of Medicaid. The White House Conferees will deal with government organization in one of the most important of the study areas assigned to them. But, instead of devoting too much of their time to the "grand design" of future governmental reform, they might simply ask: What could we lose if reorganization is too sweeping, what could we gain by improving on what we have? Regardless of administrative method, how do we assure adequate attention to the problems of the elderly?

FIVE.—The White House Conference on Aging has come under a cloud because the very agency responsible for its administration has been, in the opinion of many, downgraded by reorganizational changes in recent years. The latest blow to the Administration on Aging was a fiscal year 1972 budget request which substantially reduces funds available for vitally-needed programs. It will be up to the Congress to overrule the Administration on this issue during the next few months. But the Executive Branch should also be called upon to explain recent actions which raise serious questions about the level of priority which this Administration places upon Federal action on behalf of older Americans. Less than 2 years ago, an official of cabinet rank said that programs for the elderly resulted in very little "payoff." This was a reference to the fact that a man of 65 obviously has less longevity than a boy of 12, and therefore, investment in youth would result in more "payoff." But why should such a choice have to be made? Why not recognize the importance of providing exactly what aid is needed to help all Americans live independent, fulfilling lives, no matter what their ages? The point was made by one witness who told this Committee:

> The narrow economic cost-benefit analysis which has hitherto prejudiced public action in favor of the young is misleading in determining priorities or the base for action. It reflects the quantification of limited number of cost and benefit variables. A wider range of considerations of social costs and benefits, some of which can only be qualitatively described and appraised would make it evident that the net gains from such productive services to all branches and groups in the society would be highly profitable. Of course, the services would have to be adjusted to the needs of each group. Among the social factors to be considered in the impact of such aids to the aged and older persons, are the effects upon the individual; and national, local and family morale by preventing widespread dependence in old age. These words should be heeded by all who take part in what should be a national dialogue: our White House Conference on Aging.

In spite of the cautions expressed thus far in this preface, I believe there is more reason to look to the Conference with optimism than with foreboding.

Older Americans, speaking out at community conferences all over the Nation last September, made it clear that they have the will to be heard.

State conferees, meeting just a few weeks from now, can add to the momentum initiated by the elderly. Ten years ago, when there was no Older Americans Act, there were only a handful of State agencies on Aging. Now, there is an agency in every State in this Nation; and their influence can be a powerful force for an exciting and productive White House Conference on Aging.

Finally, during the past 10 years, the field of aging has become far too dynamic to serve as a tame subject for an inconsequential Conference. Too many issues have been raised since the 1961 Conference to be submerged. Too many solutions are only partial, though promising.

And finally, too many older Americans know that this is *their* Conference. The participants will be *their* spokesmen. If the Conference or the conferees fail them, they will want to know why.

FRANK CHURCH, *Chairman*,
Special Committee on Aging.

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APPENDIXES

EVERY TENTH AMERICAN [1]

At the turn of the century, there were 3 million older Americans—those aged 65 and over—comprising 4 percent of the total population. Today, some 20 million older individuals make up 10 percent of the total population—every 10th American. The largest concentrations of older persons—11 percent or more of a State's total population—occur in 14 States in the agricultural midwest, in New England, and in Florida. California, New York, Pennsylvania, and Illinois each have more than a million older people. By 1985, when the older population will have passed the 25 million mark, California and New York will each have more than 2 million persons aged 65 and over; Florida, Illinois, Ohio, Pennsylvania, and Texas will each have over a million.

What is this growing population like, and how does it change? Some answers:

ON NUMBERS. During the past 70 years, the total population of the United States grew to almost three times its size in 1900. The older population has grown to almost seven times its 1900 size—and it is still growing. Between 1960 and 1969, older Americans increased in number throughout the Nation by approximately 18 percent, as compared with a 13 percent growth in the total population, according to Census Bureau estimates. Greatest percentage growth (a third or more) occurred in Arizona, Nevada, Florida, Hawaii, and New Mexico. Florida had the highest proportion of older people in 1969, 13.3 percent of its total population, while New York had the largest actual number of older people, almost 2 million.

ON AGE. Most older Americans are under 75; half are under 73; a third are under 70. Almost 1.3 million are 85 or over.

ON HEALTH. Eighty-one percent get along well on their own. While only 14 percent have no chronic conditions, diseases, or impairments of any kind, the vast majority that do have such conditions still manage by themselves. Older individuals are subject to more disability, see physicians more often, and have more and longer hospital stays. In 1969, per capita health care costs for older Americans came to $692: $335 went for hospital care; $107 for physician services; $28 for other professional services; $80 for drugs; $111 for nursing home care; and $31 for miscellaneous items. Of the total amount spent for health care, $499 of the bill was taken care of by public sources, but the elderly still had to pay $193 from their own limited incomes.

ON AGGREGATE INCOME. Some $60 billion a year. More than half comes from retirement and welfare programs (52 percent),

[1] Prepared by Herman B. Brotman, Assistant to the Commissioner (Statistics and Analysis), Administration on Aging, HEW, February 1971.

less than a third from employment (29 percent), and about a fifth from investments and contributions.

ON PERSONAL INCOME. Older persons have less than half the income of their younger counterparts. In 1969, half of the families headed by older persons had incomes of less than $4,803; the median income for older persons living alone or with nonrelatives was $1,855. Almost 5 million or over a quarter of the elderly live below the official poverty line; every fifth poor person in the United States is aged 65 or over. Many of these aged poor became poor on reaching old age.

ON EXPENDITURES. Older Americans spend proportionately more of their incomes on food, shelter, and medical care. They do not necessarily need other things so much less; they simply cannot afford them—and often cannot find appropriate needed items, such as clothing, in the marketplace.

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

ON SEX. Most older individuals are women—over 11 million as compared to over 8 million men. For the total 65 and over population, there are about 135 women per 100 men; the ratio increases from 120 women per 100 men at ages 65 through 69 to 165 women per 100 men at 85 and over.

ON MARITAL STATUS. Most older men are married; most older women are widows. There are almost four times as many widows as widowers. Of the married older men, more than 40 percent have under-65 wives. An estimated 16,000 older women and 35,000 older men marry in the course of a year. Both bride and groom are 65 or over in approximately 14,000 marriages; the remaining 2,000 older brides and almost 22,000 older grooms take under-65 partners.

ON EDUCATION. Almost half never completed elementary school. Close to 3 million older people are "functionally illiterate," having had no schooling or less than 5 years. Over 6 percent are college graduates.

ON LIVING ARRANGEMENTS. Seven out of every 10 older persons live in families; about a quarter live alone or with nonrelatives. Only one in 20 lives in an institution. Most older men (about two-thirds) live in families that include the spouse but only a third of the older women live in families that include their spouse. Three times as many older women live alone or with nonrelatives as do older men.

ON MOBILITY. In the year ending March 1970, 8.6 percent (1.7 million) of all older people moved from one house to another: 6 percent moved to another house in the same county, 1.6 percent moved to a different county in the same State, and only 1 percent moved across a State line.

ON VOTING. In the 1970 elections, 57 percent of the older population actually voted; they accounted for 17 percent of all the votes cast.

INTRODUCTION AND SUMMARY

Older Americans spoke out in community forums throughout the Nation during September 1970 to begin a national dialogue which will culminate late this year with the White House Conference on Aging.*

Their comments, as reported by State agencies on aging, were centered largely upon recurring and sometimes intensifying problems: income inadequacy in the face of inflation and high medical costs and rising property taxes, cutbacks in the care provided by Medicare, transportation deficiencies, housing shortages, and much more.

Documentation for many of their criticisms are provided in the pages of this report and in reports issued by this Committee late in the year on "The Economics of Aging: Toward a Full Share in Abundance," and "Older Americans and Transportation: A Crisis in Mobility."

In the "Economics of Aging" study, the Committee once again called for broad immediate and long-term action on retirement income, with clearcut goals set before and after the White House Conference.

In the report on transportation, the Committee identified mobility problems of the elderly as a leading cause of other problems ranging from health breakdowns to isolation and melancholy.

In the report, "Developments in Aging: 1970" the Committee reports on other problems, including a housing shortage which has resulted in an estimated 6 million elderly Americans living in substandard conditions. Nursing home regulatory difficulties, too, continued during 1970 and caused intensified congressional attention.

On the positive side, every State in the Union now has a State unit on aging; many promising programs grew or were begun under the direction of the Administration on Aging, the Office of Economic Opportunity, the Department of Labor, and the Department of Housing and Urban Development. And public attention to aging seemed to mount as the White House Conference came closer and closer.

Nevertheless, as 1971 began, new concern was caused by announcements of cutbacks in budget requests for the Administration on Aging and by increasing criticism over the conduct of the White House Conference itself.

I. MAJOR LEGISLATIVE AND ADMINISTRATIVE ACTIONS

Despite frustation of Congressional intentions to pass a major Social Security reform bill during 1970, the year was marked by some progress in the following areas:

—Approval of a Senate amendment to the Labor-HEW Appropriations law to provide an additional $650,000 to pay for the delegate expenses of older Americans for the 1971 White House Conference on Aging.

*For a description of preparations for the White House Conference, see pp. 186–193, and pp. 328–331.

—Funding for the first time for the Retired Senior Volunteer Program, as well as increased appropriations for the Foster Grandparent program and the Age Discrimination in Employment Act.
—Enactment of legislation to protect 1.6 million veterans and widows receiving nonservice-connected disability pensions from loss of benefits because of the 15-percent Social Security raise in 1969.
—An increase, ranging from 8 to 12 percent, in the monthly compensation payments for more than 2 million veterans with service-connected disabilities.
—Passage of a 15-percent increase in Railroad Retirement benefits which will provide an additional $140 million for approximately 700,000 annuitants, dependents and survivors.
—A new and potentially far-reaching provision in the 1970 Housing Act which will broaden public housing coverage to include central dining facilities for aged persons who are unable to move around well enough to cook for themselves.
—Passage of legislation to authorize the President to designate the first full week in May as "National Employ the Older Worker Week."
—A last minute rescue of the successful Section 202 housing for the elderly program by providing $10 million in funding to continue such projects.
—Approval of a "pass-along" provision to assure that adult categorical recipients—the aged, blind, and disabled—will benefit by at least $4 per month from the 15-percent Social Security increase enacted in 1969.
—Adoption of a measure to allow a retired Federal employee to designate a new spouse as a survivor if his first wife predeceases him.
—Expansion of the Food Stamp Act to enable aged persons to exchange food stamps for meals prepared and served by certain nonprofit sponsors, provided these elderly individuals do not have cooking facilities or reasonable access to them.
—Provision for extending periods of unemployment insurance during times of high unemployment.

II. COMMITTEE AND SUBCOMMITTEE STUDIES

Members of the Senate Special Committee on Aging were involved in many of the developments listed above. In addition, the following hearings were conducted during 1970:

Economics of Aging: Toward a Full Share in Abundance:

Part 10A. Washington, D.C., Pension Aspects, February 17, 1970
Part 10B. Washington, D.C., Pension Aspects, February 18, 1970
Part 11. Washington, D.C., Concluding Hearing, May 4, 5, and 6, 1970

Trends in Long-Term Care:

Part 4. Washington, D.C., Marietta, Ohio, fire, February 9, 1970
Part 5. Washington, D.C., Marietta, Ohio, fire, February 10, 1970
Part 6. San Francisco, California, February 12, 1970
Part 7. Salt Lake City, Utah, February 13, 1970
Part 8. Washington, D.C., May 7, 1970

III. CONCLUSIONS OR RECOMMENDATIONS

Chapter	*Conclusions or Recommendations*	*Page*
I	Timid tinkering or stop-gap proposals will fall far short in solving the present or future retirement income problems. Bold, imaginative, and far-reaching action is needed now on several fronts. This Committee again expresses its strong support for the short-range and long-term recommendations in the Economics of Aging report, and urges that: — Congress speedily enact the Social Security Amendments adopted by the Senate, modified to include the House-passed provision for financing cost-of-living increases. — The 92d Congress give early attention to major changes in Social Security benefit levels that are needed to provide meaningful economic security for those now retired and to assure that workers retiring in the future will realize their full stake in retirement security. — Serious consideration be given to the use of general revenues in the financing of the Social Security System, with the share identified through a formula spelled out in the legislation. — The Federal commitment to the elderly undertaken through the Family Assistance Plan be translated into a wholehearted commitment, with 100-percent Federal financing and Federal administration. — Immediate attention be given to the special problem of safeguarding the retirement income of workers	10

92D CONGRESS } SENATE { REPORT
1st Session } { No. ——

DEVELOPMENTS IN AGING—1970

MARCH 1971—Ordered to be printed

Mr. CHURCH, from the Special Committee on Aging, submitted the following

REPORT

[Pursuant to S. Res. 316, 91st Cong.]

CHAPTER I

INCOME AND THE ELDERLY

Americans have been assured since 1965 that one of the objectives of their national government is to assist older persons to achieve "an adequate income in retirement in accordance with the American standard of living."

That goal, as expressed in the Older Americans Act, is far from fulfillment. And in 1970, little progress could be recorded.

It was a year of frustration:

—The Congress worked almost until adjournment to pass a Social Security bill, but time ran out.

—A rise of 5.5 percent in the cost of living caused concern and intensified hardship among many on fixed incomes.

—And it became known that the number of older Americans living in poverty had actually *increased* during a period when poverty was declining for all other age groups.

Events of 1970 were merely the latest manifestation of a hard truth expressed in a report issued in December by this Committee after a 2-year study of the "Economics of Aging."

That truth, as seen by the Committee, was:

> Our Nation, economically developed as it is, has not only failed to formulate a national policy with respect to its aged population, but it has failed to put into usable form the essential facts on which such a policy could be developed.[1]

To develop that policy and accompanying national commitment, the Committee recommended long-range, as well as short-term actions.

[1] Economics of Aging: Toward a Full Share in Abundance, S. Rep. No. 91-1548, Dec. 31, 1970, p. 5.

But its most immediate recommendation called for maximizing the opportunity afforded by the 1971 White House Conference on Aging to arrive at the policy we have thus far failed to formulate.

I. THE PERSISTENCE OF CRISIS

Despite the stop-gap 15-percent Social Security increase of 1969, older Americans continued to fight a losing race with inflated cost of living during 1970.

To judge by all available evidence, that increase in benefits barely covered the cost rise which occurred during 1969 and 1968. During the past year, with a 5.5-percent increase in the cost of living and no final Congressional action on Social Security, the squeeze on older Americans became more intense as the year progressed.

Even the prospect of payments retroactive to January 1 of this year did not hold much comfort to the elderly, unless the increases are sizeable and unless they are accompanied by major reforms in Social Security.

A. Current Data on Retirement Income

The "Economics of Aging" report provided fresh evidence of its contention that the "retirement income problem" had become a "retirement income crisis."

Among its findings:

—Aged Americans live on less than half the income of those under age 65. Median money income of families with an aged head was 47.6 percent of that for younger families in 1969. The median income of unrelated aged individuals as a proportion of the median for younger individuals was 43 percent in 1969.

—A special analysis of census data for 1968 shows that aged couples (two-person husband-wife families) had a median money income of $4,038. For individuals living alone or with nonrelatives it was $1,916 for men and $1,670 for women.

In addition, the 1968 Social Security Survey of the Aged [2] shows that:

—Of all aged units, 44 percent had income below the poverty level in 1967 ($2,020 for couples and $1,600 for nonmarried persons). Another 11 percent would have been classified as "near poor".

—Only about one-third of the aged units had incomes large enough to provide at least a moderate level of living as defined by the BLS budget for a retired couple ($3,930).

—Even, of the couples receiving Social Security benefits, more than one-fifth (22 percent) had total incomes of less than $2,020 and would therefore have been classified as poor on the basis of the 1967 income threshold developed by the Social Security Administration. Nearly three out of every five nonmarried beneficiaries had income below the poverty threshold of $1,600.

—The Social Security benefit remains the major source of income for most retirees. One-fourth of the aged couples on the rolls at the end of 1967 and two-fifths of the nonmarried beneficiaries

[2] Preliminary Findings from Social Security Survey of the Aged, Rept. No. 1, Issued by the Office of Research and Statistics, Social Security Administration, April 1970.

depended on Social Security for almost their entire support—for all but $300 per person for the year. And, significantly, there had been little improvement in this respect since the incomes of aged beneficiaries were surveyed a decade earlier.

B. Dimensions of Poverty

One of the most startling facts to emerge during 1970 was the revelation that, for the first time since poverty statistics were tabulated, the number of elderly persons on the poverty rolls *increased*—from 4.6 to 4.8 million between 1968 and 1969. In sharp contrast, the number of poor persons under 65 declined by more than 1.2 million. This rise ran counter to the previous trend which had existed between 1959 and 1968, when the number of aged persons living in poverty decreased from 6 million to 4.6 million.

The net impact of these statistics [3] is that older Americans are more than twice as likely to be poor as younger persons. One out of every four individuals 65 and older—in contrast to one in nine for younger persons—lives in poverty.

Today nearly 5 million persons 65-and-over fall below the poverty line. Another 2 million individuals in the 55-to-64 age category are impoverished. These two age groups represent 28 percent of the total poor. Yet, they comprise only 18.6 percent of the total population in the United States.

Once they retire, the poor are likely to remain poor. Others not yet poor may also become impoverished in their old age. As persons become older, there is greater likelihood that their purchasing power will be reduced. And a greater likelihood that they have (1) exhausted their assets; (2) only a relatively low Social Security benefit; and (3) no benefit under private pension plans.

Number of persons living in households with total income below the poverty line, by age group, 1959, 1968, and 1969

[In millions]

Age	1959	1968	1969		
			Number	Percent change from—	
				1959	1968
Total	39.5	25.4	24.3	−38.5	−4.3
Under 65	33.5	20.8	19.5	−41.8	−6.1
65 plus	6.0	4.6	4.8	−19.7	+3.6
Percent of total	15.1	18.2	19.7		

Source: Unpublished data, Census Bureau.

Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare, November 1970.

Minority Groups and Poverty.—Even more alarming is the incidence of poverty among elderly minority groups. *Their likelihood of being poor is twice as great as for the white aged population, and*

[3] As developed by the Administration on Aging after analysis of preliminary 1970 Census data.

four times as great as for our total population. In 1969, 48 percent of all nonwhite older Americans were victims of poverty, compared with 23 percent for whites in the same age category. Moreover, the nonwhite elderly appear to suffer from deeper extremes of impoverishment. They also reflect all aspects of the "poverty syndrome"; poor health, dilapidated housing, malnourishment, limited education, transportation difficulties, and an absence of vitally needed services.

In most cases, the experience of being without cash, food, and comfort is not new. They have lived with this all their lives. But in later years, the reality of their lifelong hopelessness is finally confirmed. They accept the inevitable, a life of poverty until they die.

Poverty among aged by race in the United States in 1969

[In thousands]

Race	Number, 65+	Total aged poor	Percent of aged poor by race
White	17, 370	4, 052	23. 3
Negro	1, 373	689	50. 2
Other races, not including white and Negro	156	46	29. 5

Source: Bureau of Census, "Current Population Reports," series P–60, No. 76. Figures do not include institutionalized population.

C. A New Class of Elderly Poor in the Making?

Unless major policy changes are made, tomorrow's retirement income problems could become even more intense than today's. Looking ahead, the economics report declared that a new group of aged poor may be in the making among those now 55 to 59. This conclusion was based on projections indicating that one out of every six men in this age group will be out of the work force by the time he reaches his 65th birthday.[4]

Many of these men, after being "eased out" of the labor force, have found it necessary to claim actuarially reduced Social Security benefits at an earlier age. As a general rule, these early retirees have lower lifetime earnings or more sporadic work patterns than those retiring at age 65. They are also more likely to be underemployed or unemployed prior to "retirement". For many—especially those who have exhausted their unemployment compensation—early Social Security with its reduced benefits may be an "escape". But for large numbers, it is also an acceptance of a life of poverty in old age.

Additional information about the characteristics of these early retirees was provided in a series of articles in the Social Security Bulletin. In a November 1970 article, these summary conclusions were provided:

> About 50 percent of currently payable awards to men are to those aged 62 at entitlement. About one in five of them has not worked for at least 12 months before his entitlement—a far higher proportion than among those who became entitled

[4] For a more detailed discussion, see pp. 20–24 and pp. 153–175 of report cited in footnote 1.

at ages 63, 64 and 65. Among the group as a whole, about six in 10 men filed either in their month of entitlement or within 3 months in advance of that month. *A certain urgency is thus implied for some of them—almost as if they were in a queue waiting for the minimum age for retired worker benefits to arrive.* [Emphasis added.]

In addition, the survey revealed:

About 25 percent of the men claiming reduced benefits and 40 percent entitled at age 65 to benefits payable at award also reported income from a private pension plan. About 9 percent of the former and 15 percent of the latter reported income from public pension sources other than Social Security. Barely one-third of men with reduced benefits had supplementary pension income in addition to Social Security benefits.

D. Older Women: Poorest of the Poor

As one leading economist, Dr. Juanita Kreps,[5] views it, "The older woman is the poorest in society today."

Today 51 percent of elderly women living alone fall below the poverty line. Especially disadvantaged are nonwhite females. For this group the incidence of poverty reaches an astonishingly high level of 77 percent, or better than three out of every four nonwhite females.

And, more and more women are becoming widows because females outlive males by an average of 7 years. There are now more than 11 million women 65 and older, contrasted with 8 million men in this same age category. A major factor in the economic plight of these widows, says Dr. Kreps, is that they receive only a fraction (82½ percent) of their husbands' Social Security benefit, instead of the full amount.

Dr. Kreps also foresees little improvement for today's 30 million working wives when they retire:

At the point of retirement, of course, the working woman will be in a better position than she is today because she will have earned more during her working lifetime. Therefore, more women will have the option to choose their own Social Security benefits rather than accept a portion as surviving beneficiary of their deceased husband's benefits.

But, Dr. Kreps predicted that the greater lifespan for women will result in the defeat of any benefits accrued from their working years.

She, too, will be faced with the poorest position in society because her retirement income won't stretch over the greater number of years she is in retirement. Also, if women continue to earn less than men their retirement benefits will be proportionately less.

The Economics of Aging report—which also discussed the intensified problems of elderly women—gave several examples taken from

[5] As quoted in a release issued by the staff of the White House Conference on Aging, Dec. 31, 1970. Dr. Kreps—Professor of Economics and Dean of the Women's College at Duke University, in Durham, N.C.—was a member of the Task Force which prepared the initial "Economics of Aging" Working Paper. She is also a member of the Technical Committee on Income for the White House Conference on Aging.

the testimony of those directly affected by the problem. Among those examples:

Mrs. W receives $105 from Social Security. She is aged 77. She pays $120 per month rent, plus $10 for utilities. She receives Meals on Wheels but she lacks sufficient money for fuel.

Mrs. G is blind in one eye. She receives $77 from Social Security. She needs supplementary welfare. She is depressed because she cannot work. She has a retina detachment and she is heavily indebted. She pays $100 rent.

Mrs. K, aged 80, receives $109 in Social Security. She is crippled, she lives alone, she must be transported to the hospital and to shopping. She pays $90 rent.

II. SOCIAL SECURITY AND WELFARE: ATTEMPTS AT REFORM

Unsuccessful though they may have been in 1970, efforts to improve the Social Security bill and to enact a Family Assistance Program advanced several proposals that would—if enacted in the near future—make significant progress toward greater economic security for the elderly.[6]

A. House, Senate Versions of Social Security

With overwhelming bipartisan support, the House and Senate approved legislation making important reforms in Social Security—improvements representing a major step forward in coping with the present retirement income crisis. Particularly welcome was the proposed benefit increase—a 10-percent raise in the Senate bill, compared with 5 percent in the House proposal.[7] Equally important was the substantial increase in minimum monthly benefits in the Senate version—from $64 to $100—which would have helped to lift large numbers of elderly persons out of poverty. With its 5-percent across-the-board rise, the House bill would have increased the minimum only by $3.20 per month, to $67.20.

Both bills liberalized the retirement test by raising the annual amount that a beneficiary under age 72 may earn without loss of benefits (to $2,000 in the House bill and to $2,400 in the Senate version). For earnings exceeding these exempt amounts, the bills would provide for a $1 reduction for each $2 of earnings.

Both bills increased the widow's benefit to 100 percent of the primary amount received by the deceased spouse. And both bills corrected an inequity in the present benefit for men who retire before age 65 by providing an age-62 computation point, the same as now exists for women.

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[6] The Senate passed the 1970 Social Security Amendments (H.R. 17550) by a vote of 81 to 0 on Dec. 29, 1970. However, no conference committee was held because Congressman Wilbur Mills, Chairman of the House Ways and Means Committee, believed that it would have been impossible to work out the differences in the House and Senate bills during the closing moments of the 91st Congress. But in his floor remarks on Dec. 31, Mills stated, "There will be reported from the Committee on Ways and Means as soon as possible after we reconvene a bill which will provide Social Security benefit increases across-the-board."

[7] In 1971 Congressman Wilbur Mills and Congressman John Byrnes (the ranking majority and minority members, of the House Ways and Means Committee) sponsored legislation, H.R. 1, calling for a 10-percent increase in Social Security benefits effective January 1, 1971—the same effective date for the proposed benefit raise in the 1970 Social Security Amendments.

A major innovation was the provision for automatic adjustments in benefits for each 3-percent rise in the cost-of-living. However, the Senate bill stressed the predominant role of Congress in determining adequate benefit levels. Under the Senate bill, the automatic escalator would serve as a "back-up" to assure that in the absence of Congressional action, the real value of benefits would not be eroded by rising prices. Another difference in the two bills concerned the means for financing the cost-of-living increases (with 50 percent coming from a raise in the tax rates and the other 50 percent—rather than 100 percent as in the House bill—from an increase in the taxable wage base).

B. FAP: A Major Advance Over Old Age Assistance

The Committee's Economics of Aging report also strongly endorsed the efforts to reform the welfare programs for Americans of all ages and described several promising proposals, as advanced in the Administration's Family Assistance program and in refinements urged by congressional units. For the 2 million old-age assistance recipients, both the House and Senate passed adult categorical assistance measures which would represent major improvements.

In the House Family Assistance Plan, a combined Federal-State program for the needy aged, blind and disabled would replace the three separate existing programs. Under the House proposal, States would be required to provide a payment sufficient to bring an adult welfare recipient's total income up to at least $110 per month ($220 for a couple), or, if higher, the standard presently in effect.

In the Senate bill, the Federal minimum floor would be $130 a month for a single person and $200 for a couple. For many of the aged on welfare, these thresholds would come close to spelling the end of poverty. But the Senate version—unlike the House-passed Family Assistance Act—would make adult categorical recipients ineligible to participate in the Food Stamp program.

Today millions of aged persons with incomes below the poverty level do not receive welfare assistance, presumably because many are unaware of its availability, or they are unwilling to be subjected to a demeaning means test. Yet, any attempts for real reform must take into account changes that make the conditions under which welfare is paid both widely known and publicly acceptable.

Also significant were welfare reform proposals urged by the President's Task Force on the Aging. Among the major proposals: (1) The Federal Government should bear 100 percent of the cost of financial assistance to bring the elderly's incomes up to the poverty threshold; and (2) welfare payments, as well as eligibility determinations, should be made through the Social Security district offices.[8]

III. COVERAGE BY PRIVATE PENSIONS

One of the most crucial issues debated during the year was the role and adequacy of private pensions in providing retirement security for older Americans. With widespread unemployment causing thousands of mature workers to lose their pension rights as well as their jobs, the inquiry became more intense.[9] And hearings held by this Com-

[8] Toward A Brighter Future For The Elderly, the report of the President's Task Force on the Aging, April 1970. p. 25.

[9] For more detailed discussion on the effect of unemployment on pension rights, see p. 89, ch. VII.

mittee—as well as a working paper prepared by Dr. James Schulz [10]—provided additional evidence that there is still little reason for the aged of today and workers now approaching retirement to be complacent. In his working paper, Dr. Schulz pointed to a number of considerations for this warning:

—Even under earlier projections now known to be too optimistic, only a third to two-fifths of all elderly persons in 1980 are expected to have income from private group pensions.
—Approximately 75 percent of all beneficiaries under private pensions in 1980 are projected to have income below $2,000, even if a significant upward turn in benefit levels is assumed.
—Coverage today still tends to be concentrated among higher paid workers, meaning those most in need of supplemental income in retirement are least likely to have help from private pensions.

His projections with regard to future pension income from private sources were called both too optimistic and too pessimistic. But most experts agreed with Dr. Schulz that major reforms would be necessary if private pensions are to provide greater economic security, although there were considerable differences as to the dimensions of the problem as well as proposed solutions for these issues.

Extensive hearings conducted on private welfare and pension plan legislation by the General Labor Subcommittee of the House Education and Labor Committee also provided new information on such important issues as (1) minimum standards for vesting and funding of private pensions, (2) insurance protection against termination, and (3) fiduciary responsibilities of managers of pension assets.

LABOR SUBCOMMITTEE SURVEY

Another significant development was a comprehensive study initiated by the Senate Labor and Public Welfare Committee. A 48-question survey sent to 34,000 private retirement plans is designed to elicit basic information regarding the structure and administration of pension plans, eligibility requirements, vesting standards, benefit payment levels, forfeiture rates, fiduciary standards, and other issues. This information is now undergoing comprehensive analysis with a view toward utilizing the results for proposed legislation to provide vesting, funding, reinsurance, and fiduciary standards.

PRESIDENT'S TASK FORCE

The role and potential of the private pension system received searching inquiry by the President's Task Force on the Aging. Two major recommendations evolved from this study: (1) An independent Pension Commission should be established to engage in activities which will result in the fullest protection of employee rights; and (2) the President should direct the Commission to enlist the help of the financial community in designating a portable voluntary pension system as a companion to the Social Security system.[11]

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[10] Dr. James Schulz, Associate Professor of Economics, Brandeis University, and Economics of Aging Task Force member.
[11] Toward a Brighter Future for the Elderly, the report of the President's Task Force on the Aging, April 1970, pp. 19–20.

IV. SOME LEGISLATIVE VICTORIES

Though disappointing for the elderly in many respects, 1970 brought a number of laws that will provide important relief for persons living on limited, fixed incomes. Among the major proposals:

Railroad Retirement Annuitants.—A 15-percent increase in Railroad Retirement benefits—paralleling the earlier 15-percent Social Security boost—will provide approximately 700,000 annuitants, dependents and survivors with an additional $140 million.[12] The increase would be limited to a monthly maximum of $50 for employee anuitants and $25 for spouses and survivors. If a retiree also receives Social Security benefits, his annuity raise would be reduced by the amount of the 15-percent Social Security increase. However, a retiree would receive at least a $10 monthly raise under Railroad Retirement, and his spouse at least a $5 monthly increase, regardless of the increased benefits under Social Security. The new law also establishes a commission to make a study regarding the financing of the Railroad Retirement system and benefit levels under the program.

Veterans With Service-Connected Disabilities.—With the signing of Public Law 91–376, more than 2 million veterans with service-connected disabilities received increases ranging from 8 to 12 percent in their compensation payments. The new law went into effect on July 1, and will make the following changes:

Disability	Previous law monthly amount	Public Law 91-376 monthly amount
(*a*) Rated at 10 percent	$23	$25
(*b*) Rated at 20 percent	43	46
(*c*) Rated at 30 percent	65	70
(*d*) Rated at 40 percent	89	96
(*e*) Rated at 50 percent	122	135
(*f*) Rated at 60 percent	147	163
(*g*) Rated at 70 percent	174	193
(*h*) Rated at 80 percent	201	223
(*i*) Rated at 90 percent	226	250
(*j*) Rated at total	400	450

Protection Against Loss of Pension Benefits.—Approximately 1.6 million veterans and widows receiving nonservice-connected disability pensions will be assured that they will not lose any of their pension benefits because of the 15-percent Social Security raise in 1969. In many instances, the 15-percent increase would move a veteran into a higher income bracket—causing a reduction or possibly even a termination of his monthly VA pension. However, Public Law 91–588 will raise income limitations to take into account the Social Security raise. In addition, virtually all of the 1.6 million beneficiaries will receive an average pension increase of about 10 percent.

V. WHAT NOW MUST BE DONE

The Committee on Aging, in adopting the recommendations advanced by its report on the Economics of Aging, said it is essential for the Committee to declare, as forcefully as it can, that:

[12] Public Law 91–377, approved Aug. 12, 1970.

> Our Nation during this 35th anniversary year of the Social Security program (1970), has not yet resolved retirement income problems which severely damage the economic status, morale, and even the health of millions of Americans, including many well above the poverty line.

But the Committee pointed out that:

> It is within the power of this Nation, if it takes full advantage of several unique opportunities during the remaining 11 or so months before the White House Conference on Aging—and in the months immediately following that conference—to make the 1970's the decade in which this Nation achieves its declared goal of "an adequate income in retirement in accordance with the American standard of living."

Timid tinkering or stop-gap proposals will fall far short in solving the present or future retirement income problems. Bold, imaginative, and far-reaching action is needed now on several fronts. This Committee again expresses its strong support for the short-range and long-term recommendations in the Economics of Aging report, and urges that:

- **Congress speedily enact the Social Security Amendments adopted by the Senate, modified to include the House-passed provision for financing cost-of-living increases.**
- **The 92d Congress give early attention to major changes in Social Security benefit levels that are needed to provide meaningful economic security for those now retired and to assure that workers retiring in the future will realize their full stake in retirement security.**
- **Serious consideration be given to the use of general revenues in the financing of the Social Security system, with the share identified through a formula spelled out in the legislation.**
- **The Federal commitment to the elderly undertaken through the Family Assistance Plan be translated into a wholehearted commitment, with 100-percent Federal financing and Federal administration.**
- **Immediate attention be given to the special problem of safeguarding the retirement income of workers who lose their jobs as a result of plant shutdowns, commonly after long service and who—like the deteriorating plants that are first to be shut down—are likely to be middle-aged and older.**
- **The 92d Congress give prompt consideration to legislation establishing an Institute on Retirement Income.**

Further, this Committee recommends that:

- **Prompt action be taken to increase retirement benefits for Railroad Retirement annuitants and Civil Service pensioners.**
- **Income limitations for veterans receiving nonservice-connected disability pensions be raised to take into account Social Security increases passed by Congress.**
- **The retirement income credit be modernized to provide more meaningful tax relief for retired teachers, firemen, policemen, and other government annuitants.**

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON INCOME

The 1961 White House Conference was carefully designed to recognize the importance of interrelated consideration of the broad economic aspects of income in old age. The recommendations adopted by the Income Maintenance Section were formulated with the help of participants assigned to three other sections—Population Trends, Social and Economic Implications; Impact of Inflation on Retired Persons; and Employment Security and Retirement.

By viewing the specific issues of income maintenance against a broad economic background, the conferees were enabled to develop recommendations less likely to be in conflict with other recommendations and more likely to lead to a broad national policy.

I. RECOMMENDATIONS IN 1961

There was general agreement that, while the aged should have a chance to work, increased employment opportunities cannot be a substitute for adequate income maintenance programs. There was agreement too, that the pluralistic approach—with the individual saving on his own, the individual and his employer joining in private pension arrangements, and the individual and his government joining in social insurance and assistance programs—is the best way of providing income for the retired aged.

Against this broad frame of reference major specific recommendations included:

—Adjustment of Social Security benefits from time to time to maintain their purchasing power, with additional increases to permit the retired to share in rising productivity.

—Maintaining the principle of a retirement test so that Social Security funds are reserved for those who are substantially retired.

—Improvements in the Federal-State assistance programs with the view of assuring all aged persons a reasonable minimum level of living under conditions which preserve their dignity and self-respect.

—Strong encouragement, including expanded tax incentives, to the growth and improvement of private pension plans.

—A variety of approaches to the large and complex problems of financing health costs, including expansion of voluntary health insurance, full implementation by the States of the Federal legislation providing medical aid for public assistance recipients and the medically indigent, and establishment of a program of health benefits for the aged financed in the same way as Social Security cash benefits.

II. THE RECORD SINCE 1961

In the decade of the sixties, the income of the elderly population has risen. But, despite periodic increases in Social Security benefits, the income gap between older and younger families has widened. The median income of families with an aged head dropped from 49.1 percent

of the median of younger families in 1960 to 47.6 percent in 1969. The relative position of single individuals improved slightly over the same period, with the median income of the aged rising from 41 to 43 percent of the median for younger individuals.

The number of aged persons living in poverty decreased from 6 million in 1959 to 4.8 million in 1969, a slower rate of decrease than that for the younger population. Moreover, the downward trend over the decade was reversed in 1969 when both the number and proportion of aged poor increased over 1968.

In 1969, older Americans were twice as likely to be poor as younger persons. One out of every four persons 65 and older—in contrast to one in nine younger persons—was living in poverty.

Of special significance to conferees charged with responsibility for recommending steps to reduce poverty of the aged are these two developments:

1. Despite a drop in the overall proportion of the aged who were poor, the number of widows and other aged women living alone in poverty increased over the years.
2. Between 1968 and 1969, there was an increase in the number of aged men who were poor, perhaps as a result of having been eased out of the labor force before age 65 and claiming permanently reduced Social Security benefits even though they had little else in other retirement income.

Conferees in 1971 will have to face much the same fact faced by the 1961 conferees; the Social Security benefit remains the major source of income for most retirees. One-fourth of the aged couples on the roles at the end of 1967 and two-fifths of the nonmarried beneficiaries depended on Social Security for almost their entire support—for all but $300 per person for the year. And, significantly, there had been little improvement in this respect since the incomes of the aged beneficiaries were surveyed a decade earlier.

III. ISSUES IN 1971

A Task Force which issued the first working paper on the "Economics of Aging" study defined issues related to retirement income both in terms of basic public policy issues and those directly related to Social Security.

That summation of issues is repeated here in the belief that it will be helpful to those now attempting to arrive at a definition of issues which will receive attention at the 1971 White House Conference on Aging.

A. Basic Public Policy Issues [13]

—What is an adequate level of income for retired persons? Adequate in relation to the individual's level of living before retirement? Adequate to keep the average older person from want and dependency? Adequate to permit participation in the Nation's rising standard of living?

—What part in attaining this level should be played by governmental programs, by voluntary group action and by individual effort?

[13] Economics of Aging: Toward a Full Share in Abundance, Senate Report No. 91-1548, Dec. 31, 1970, p. 57.

And of the public segment, what share should be financed through payroll taxes and what through general revenues? What level should be provided by governmental programs as a matter of right without a means test?

—Is the economic problem of aging a temporary problem that requires a different solution—or a different "mix" of solutions—for today's aged than for those reaching old age in the future?

B. Issues Specific to Social Security [14]

—By how much should the general level of cash Social Security benefits be increased to provide a basic floor of protection?

—Should benefits be raised for special groups of beneficiaries, particularly for widows, for those now drawing the minimum benefit, and for those who will become entitled in the future who have had earnings significantly above the present maximum earning base that is credited for benefits?

—Should the eligibility age for benefits be lowered? Should benefits payable before age 65 be computed without an actuarial reduction?

—Should the test that results in the withholding of benefits because of earnings be liberalized? eliminated?

—Should benefit adjustments be made automatically or through legislative amendments? And should adjustment be to a level that merely preserves—or restores—purchasing power, or to a level that provides a share in the Nation's increased productivity?

—How appropriate are the available indexes, including the Consumer Price Index, as measures of the need for adjustment and the amount of adjustment in retirement benefits?

—What improvements are needed in Medicare benefits? Should the voluntary medical insurance portion (Part B) be financed—as is the hospital insurance portion (Part A)—through rising earnings of workers rather than through premiums paid by the aged?

—What role should general revenues play in the financing of the Social Security system?

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[14] Economics of Aging: Toward a Full Share in Abundance, Senate Report No. 91–1548, Dec. 13, 1970, pp. 62–63.

CHAPTER II

HEALTH: THE QUESTIONS DEEPEN

> "Health care expenditures in the United States are second only to those for national defense. Every sign points to further increases. Despite this, there is evidence that the American people, especially the elderly, are not receiving the health care they need and for which they are paying."
>
> —Presidential Task Force Report, 1970 [1]

Medicare and Medicaid—the major programs passed by the Congress in 1965 to provide health services to the elderly and to other Americans—were under intensive scrutiny 5 years later. Critics said that the programs were too costly, subject to widespread abuse, and inefficiently administered. Older Americans had an entirely different set of criticisms; they complained with increasing frequency about rising costs of medical care, serious gaps in Medicare coverage and Medicaid assistance, and of new regulations which diminish the protection offered.

The prospect of widespread debate on some form of national health protection—whether it is the "Health Security" universal coverage and reform program or the proposals advanced by the Executive Branch—helped assure that the scrutiny will intensify rather than diminish. In the search for a far-reaching plan to serve all Americans, however, the opportunity to improve existing programs for the elderly should not be overlooked.

I. THE CONTINUING COST PUSH

America's medical bill in 1970 amounted to $70 billion, 11 percent more than in 1969 and approaching three times the amount 10 years earlier ($26 billion in 1960).

Of the growth in medical expenditures in the last decade, fully 60 percent can be attributed to inflation—not additional or better health services. Since 1960, medical costs have gone up twice as fast as the cost of living; hospital costs, five times as fast.[2]

Families even though well-to-do, are faced with costs for serious illness that are beyond reasonable financial reach. More and more of our elderly people, despite some protection from Medicare, are having to go without the medical care they badly need.

[1] Toward a Brighter Future for the Elderly, the report of the President's Task Force on the Aging, April 1970, p. 29.

[2] For additional details, see "National Health Expenditures, 1929–70," by Dorothy Rice and Barbara S. Cooper, Social Security Bulletin, Jan. 1971; and "National Health Expenditures, Fiscal Years 1929–70 and Calendar Years 1929–69," prepared by Barbara S. Cooper and Mary McGee, Division of Health Insurance Studies, Social Security Administration, in Research and Statistics Note 25, Dec. 14, 1970.

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A. Effect Upon Elderly

In a period marked by such intense inflation, the mere passage of time compounds the problems of financing health costs for the aged. Their costs for the protection of Medicare increase. And the amounts they must pay out of pocket can skyrocket. For each older individual costs become increasingly unpredictable.

The Senate Special Committee on Aging in its report on the "Economics of Aging," pointed to the unevenness of the impact of heavy health costs, saying:

> Averages, especially in relation to health costs, can be very deceptive. Most older people share in the expenditures for physicians' services. In contrast, the bill for hospital care and for nursing home care (which accounts for as much as 45 percent of all expenditures other than hospital and physicians' services) is concentrated on a smaller portion of the aged population during the course of any 1 year. So too is there great variation in the average protection older people have against health costs. Medicare does a much better job of covering the costs of a serious illness requiring hospitalization than it does in relation to recurring doctor bills; and Medicare leaves uncovered the drug expenditures for chronic conditions that plague so many older people as well as long-term nursing home bills.[3]

With this caution, these are the most recent facts about the total health bill for the aged population:

—In fiscal year 1969, the average health bill for a person 65 or older was $692, six times that for a youth and two and one-half times that for a person aged 19–64.

—Of the average health bill for an aged person, $335 was for hospital care, $107 for physicians' services and $250 for all other types of health expenditures.

—In the 2-year period ending June 30, 1969, health expenditures for the aged rose to 42.2 percent, twice as fast as the expenditures for younger persons. The faster rise for the aged reflected the growing importance of Medicare as a source of funds in addition to such factors as population growth, rising prices per unit of service, the increase in per capita utilization, and the rising level and scope of services.

—Medicare covered nearly half (47 percent) of the total personal health care expenditures of the aged in fiscal year 1969, leaving uncovered an average health bill considerably larger than the total health bill for the average younger person.

—When Medicaid and other public programs are included, 72 cents of every $1.00 of expenditures for health care of the aged came through public programs.

—Older people insured by Medicare are now paying $5.30 per month in Part B premiums and an increase to $5.60 per month as of July 1, 1971, has just been announced. This represents nearly a doubling in the monthly premium since the program was launched 5 years ago.

[3] Economics of Aging: Toward a Full Share in Abundance, Senate Report No. 91–1548, Dec. 31, 1970, pp. 15–16.

—The payments that the patient in a hospital or extended care facility must make under Part A of Medicare have also increased. The payment rates that go into effect on January 1, 1971, are 50 percent higher than when the program was started (for example, the patient must pay the first $60 of the hospital bill instead of the first $40).

B. The Relationship to a Disorganized System

"Our American medical system is characterized by the fact that there is no identifiable point of public accountability. To whom can the older patient go and say, 'I don't like what's going on; who is going to do something about it?' " Dr. S. J. Axelrod, director of the Bureau of Public Health Economics, University of Michigan, concluded a statement to the Committee's Subcommittee on Health with the above indictment.[4]

Dr. Axelrod identified the following problem areas in our current health care system that are accentuated in the case of the aged because of their lower incomes, their greater need for long-term care, and our lack of adequate alternatives to hospital care:

> First of all, there is a heavy economic burden. I would like to point out that the high and rising costs of medical care are an inevitable accompaniment of our increased technology. We can do very much more for people in terms of preventing premature death and controlling disability and we must be prepared to pay those costs. Having said that, let me add very quickly, putting more money into our medical care system as it is currently constituted does not guarantee increased effectiveness nor increased productivity.
>
> A second major problem has to do with shortages—important shortages of all kinds of manpower, health manpower. These shortages are being accentuated again by the increased technological base in the delivery of medical care. There are important shortages in facilities for caring for all kinds of people, particularly persons who have need for long-term care.
>
> A third major feature of our modern delivery system is that there are important variations in the quality of care.
>
> Fourth, we need to recognize that our system is a nonsystem as the chairman has indicated. Health services are not continuously available to people. It is difficult to get a physician to give care at nights and on weekends. In increasing fashion the emergency rooms of hospitals are being used in place of the family physician and there is some question about the adequacy of the staffing of the emergency rooms in our larger hospitals.
>
> Health services are not available to people in the ghetto. There has been a migration of physicians out of the ghetto. Health services are not readily available to people in rural areas where there are great shortages as has been indicated so many times.

[4] Economics of Aging: Toward a Full Share in Abundance—Part 3—Health Aspects, July 18, 1969, Washington, D.C., p. 499.

> In addition we know there is inappropriate use of personnel and facilities. Highly trained manpower in short supply is being inappropriately used, hospitals with their high costs are being inappropriately used. Along with shortages we have the uncomfortable concomitant of duplication.[5]

Other witnesses too recognized the inevitability of rising costs in a "nonsystem" which lacks organization and public accountability. Drawing upon the lessons learned from Medicare, they stressed two essential principles:

> First, it is not enough for the government to provide only a financing mechanism for health costs; there is an attendant responsibility for assuring the delivery of high quality and effective services. And second, there are serious problems built in from the start if the focus of the health care system is on the aged—the highest risk group; as one witness put it: "This is the logic for writing automobile insurance for people only when they are intoxicated."

The Federal role.—A Subcommittee of the Senate Government Operations Committee, after a 2-year study of the "chaos and disarray of private health care services," issued its summing-up report[6] in April 1970.

Its major conclusion: "Federal health programs comprise a cumbersome, disjointed bureaucracy that key Government officials have difficulty managing."

Reasons for this conclusion, as argued in the report, were:

—Federal programs have not attempted to come to grips with rising health care costs.

—Federal programs have only touched on the problem of limited access to care.

—Federal programs have not tried to pull together, or provide incentives to develop models of organized delivery systems for the general population.

—Federal programs have been woefully inadequate in dealing with the shortage and distribution of health manpower.

In addition, the Subcommittee found that "there is no national health policy to provide form and direction to Federal health programs and expenditures."

It was against a backdrop of such mounting criticisms of the health system in general—and the Federal role in intensifying them[7]—that the Medicare and Medicaid programs received increasing attention by Congress, by Federal study groups, and by private health organizations.

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[5] Economics of Aging: Toward a Full Share in Abundance—Part 3—Health Aspects, July 18, 1969, Washington, D.C., pp. 498–499. S. J. Axelrod, M.D., School of Public Health, University of Michigan.

[6] "Federal Role in Health," p. 29, Senate Report No. 91–809, issued by the Subcommittee on Executive Reorganization and Government.

[7] In spite of the generalized critiques, several promising moves have been taken in terms of health care related to the elderly. A coordinator for Health of the Aging is now at work in the Community Health Service of the Health Services and Mental Health Administration. In addition, a consultant has been assigned to work with an inter-agency Federal Secretariat for the Technical Committee on Health of the White House Conference on Aging staff. In 1970, volumes II and III of the 4-volume series entitled "Working with Older People: A Guide to Practice," were released. For additional details, see Appendix 1, report by the Health Services and Mental Health Administration.

II. CRITICISMS OF MEDICARE AND MEDICAID

During 1970, the 91st Congress continued a searching inquiry into the Medicare and Medicaid programs. The focus of this inquiry was primarily on the control of costs, not on improvements in protection.

A 2-percent special allowance in the hospital reimbursement formula under Medicare was removed in fiscal year 1970. A special effort was also made to tighten controls on the use of extended-care facilities under the Medicare programs. The result was a reduction in expenditures for this purpose from $367 million in fiscal year 1969 to $295 million in fiscal 1970.

During the same period, there was a significant decrease in the length of hospital stays of the aged—coupled with only a slight increase in hospital admissions. Thus, the total of hospital days for the aged rose by only 0.6 percent in fiscal year 1970, compared with a 7 percent increase in the previous years.

These are major factors in accounting for a slowdown in the rate of rising Medicare expenditures. The $7.1 billion spent under the Medicare program in fiscal year 1970 was only 8 percent more than in 1969—about one-third the 23 percent increase registered in the previous year.

This slowdown in the rate of spending under Medicare is commendable only if accompanied by no loss in the benefit protection of the elderly consumer.

Medicaid expenditures, too, rose at a slower rate in 1970 than in the previous year. Expenditures in fiscal year 1970 amounted to $4.9 billion. This was a rise of 18 percent compared with a 26 percent increase in the previous year.

Faced with rising public spending for Medicaid, legislation considered in the 91st Congress would have repealed the provision now in the Social Security Act requiring States to have comprehensive Medicaid programs by 1977.

The Committee, in its report on the Economics of Aging, questioned what it saw as an attempt to downgrade Medicaid, saying:

> The repeal of the requirement has been explained as for the purpose of relieving the States of an increasingly heavy burden for Medicaid. One cannot help but interpret this change in Medicaid, however, as the initial step toward phasing out Medicaid, particularly since the Administration has promised to develop a proposal for a Family Health Insurance Plan by February 1971. This proposed health insurance plan, as explained by the Administration, will relate only to families with children who are eligible under the Family Assistance Plan. It would offer no protection to those who receive cash assistance because of age, blindness, or disability, or to millions of other medically needy older persons—including those eased out of the labor force before becoming eligible for retirement benefits. It would offer no protection to those over age 65 for the costs not covered by Medicare—and Medicare covers less than half the total medical bill of the average aged person and a much smaller proportion of the medical bill of those with heavy drug costs or expenses for nursing home

> care. For these millions of older people, the need is for an improved and expanded program of protection against health costs, not a drawing back from the basic commitment under Medicaid.[8]

The Committee's foreboding would appear to be confirmed by the President's Health Message, sent to the Congress on February 18, 1971, which—in announcing the long-awaited Family Health Insurance Plan—states:

> The current Medicaid program for the aged, blind and disabled will remain in effect for those categories of persons.

The record of 1970, while largely responding to criticisms of Medicare and Medicaid through cutbacks, does hold forth significant hope for improved medical care for the elderly. The hope lies in the surge of support for nationwide development of Health Maintenance organizations which would provide comprehensive, coordinated health care through prepaid group health plans that emphasize regular servicing and other health maintenance practices.

III. PROPOSALS FOR CHANGE

"The Medicare and Medicaid programs are in serious financial trouble," said the Senate Finance Committee report issued early in 1970.[9] To document its conclusion, the staff report said that the estimated cost of Medicare for calendar year 1970 jumped from the original projection of $3.1 billion to a then-current estimate of $5.8 billion.

"And," it added, "from 1970 onward, the yearly gap between original estimates of costs and current projections progressively widens by billions of dollars."

As for Medicaid, the report said that the budgetary impact upon State, local, and Federal governments had been "enormous," increasing from $1.3 billion in fiscal year 1965 to $5.5 billion in fiscal year 1970. It added:

> Federal expenditures for medical assistance will have increased five-fold from fiscal year 1965 through fiscal year 1970 with commensurate increases in expenditures by State and local governments.

To reduce the costs, the staff report offered many recommendations dealing with long-term care institutions (see Chapter IV). It also suggested new methods for payments of physicians' fees, incentive reimbursement methods for hospitals and physicians, closer evaluation of Medicare carriers, and far-reaching improvements in Medicaid administration. (See Appendix 5—Developments in Aging: 1969, for a summary of the report and its recommendations.)

As the Senate Finance Committee pressed for actions on its recommendations during the year, the Administration, an Advisory Commission on Medicaid, and a Presidential Task Force also offered proposals that could have far-reaching effect. In the process, a sharper definition of the proposed Health Maintenance Organization emerged.

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[8] Report cited in footnote 3, p. 18.

[9] Medicare and Medicaid: Problems, Issues, and Alternatives, report of the staff to the Committee on Finance, Feb. 9, 1970.

A. The McNerney Report and HMO's

Appointed in 1969, the Task Force on Medicaid and Related Programs—as established by the Department of Health, Education, and Welfare—had begun, by the end of that year, to work their way to definitions of "innovative facilities for the provision of medical care." (See Item 2, Appendix 4, "Developments in Aging: 1969.")

Under the Chairmanship of Blue Cross Association President Walter J. McNerney, the Task Force issued its final report June 29 and clearly linked the financial difficulties encountered in Medicaid (and Medicare) to deeprooted organizational deficiencies in the Nation's medical care resources.

"Fundamentally," said the report, "the problems of Medicaid lie beyond the walls of Medicaid. The Task Force is strongly convinced that the current health system has serious organizational financing, productivity, and access problems and that bolder moves that have characterized the last few years are needed to achieve measurable improvement.

"Appreciable investment of funds will be needed; but, importantly, significant changes in our delivery system are required. There are no easy solutions. The strategy of leadership and implementation will be complex inevitably, not only because the country is vast and diverse, but also, because the health field, like most human service fields, lacks self-regulation and its traditions run deep.

"This suggests the desirability of building on the good that exists while seeking, selectively, levers for effecting change utilizing the assets of the public and private sectors, neither of which, alone, can accomplish the job to be done." [10]

Under which comprehensive medical care services, including checkups and other medical maintenance activities to *prevent* disease, could be employed in public programs such as Medicare and Medicaid.

The McNerney Task Force recognized, that HMO's offer "a promising option or alternative that may take its place in the system and vie with other methods on the basis of appropriateness of service and economy of performance," and that "this kind of competition among organizational modes within the system is regarded by the Task Force as desirable because it may stimulate performance by offering choices to both consumers and providers of care."

In Administration testimony during 1970, stronger and stronger support for the HMO concept was expressed. (In his message on health in February 1971, President Nixon adopted the HMO as a key element in his national health strategy.)

Other points of emphasis and recommendations in the June 1970 McNerney report:

—Medicaid should be converted to a program with a uniform minimum level of health benefits financed 100 percent by Federal funds, with a further Federal matching with States for certain types of supplementary benefits and for individuals not covered under the minimum plan.

—First priority for protection under a basic Federal floor for Medicaid should go to all families eligible for payments under

[10] Report of the Task Force on Medicaid and Related Programs, June 29, 1970, p. 2.

the proposed Family Assistance Plan. Additional groups should be phased in until all persons at, or below, the poverty level are covered.

—Support was expressed for current legislation for health cost effectiveness changes in Medicare and Medicaid, including prospective reimbursement to hospitals and planning controls.

B. The President's Task Force on Aging

Unlike the McNerney Task Force [11]—which had been assigned to evaluate an ongoing medical assistance program as it affects all age groups—the President's Task Force on Aging had been requested solely to focus its attention on a *single age group* and the effects of programs and other social forces upon them. Thus, while there are similarities between the Task Force recommendations, the Task Force report on "Toward a Brighter Future for the Elderly" in April 1970 was focused more upon the consumer of health services rather than the mechanisms for providing those services.

The Task Force on Aging made these recommendations on health care:

MEDICARE MODIFICATIONS—RECOMMENDATION 11

We recommend that Medicare be modified to provide: 1) coverage for extended care and home care without prior admission to an acute care hospital; 2) expanded coverage for home care; 3) coverage of out-of-hospital drugs at the earliest date administratively feasible; 4) removal of the 100-day time limit on skilled nursing home care for those patients who continue to need such care; and 5) coverage for early diagnostic and other preventive measures.

GERIATRIC SERVICES THROUGH NEIGHBORHOOD HEALTH CENTERS—RECOMMENDATION 12

We recommend that the President seek congressional authorization for front-end financing from the Medicare Trust Fund of a full range of geriatric health services including community health aides devoted exclusively to working with the elderly, transportation to and from health facilities, home care, and preventive techniques such as screening and health education. We further recommend that, wherever possible, these services be delivered through neighborhood health centers. We also recommend that the number of such centers be expanded through front-end financing from the Medicaid appropriation.

ELIMINATION OF MEDICARE RESTRICTIONS ON PSYCHIATRIC CARE—RECOMMENDATION 13

We recommend that the restrictions in Medicare coverage on out-patient psychiatric care be removed so that Medicare pays the same benefits for out-patient psychiatric treatment as it does for all other

[11] For a summary of recommendations made by the Task Force on Medicaid and Related Programs in June 1970 for the Department of Health, Education, and Welfare, see Appendix 8, p. 333.

medical care. We further recommend that the 190-day lifetime limitation under Medicare for in-patient treatment in a psychiatric hospital be removed.

ESTABLISHMENT OF A COMMISSION ON MENTAL HEALTH OF THE ELDERLY—RECOMMENDATION 14

We recommend that the President request Congress to authorize the appointment of a Commission on the Mental Health of the Elderly comprised of representatives from concerned Federal agencies, national organizations, Congress, and the judiciary, and private citizens to study, evaluate, and recommend a comprehensive set of policies for the Federal Government, the several States, and local communities to pursue in this vital area.

PROGRAM OF RESEARCH REGARDING HEALTH CARE FOR THE ELDERLY—RECOMMENDATION 15

We recommend that the Health Services and Mental Health Administration establish within the National Center for Health Services Research and Development a Council for the study of the organization, planning, management, financing, and delivery of health care for the elderly. We further recommend that within a reasonable period of time this Council design, conduct, and report on large scale experiments concerning comprehensive coverage, incentives for comprehensive care which could be added to existing health programs, and the effect of removing or reducing the deductible and coinsurance features of Medicare.

C. Recommendations in "Economics of Aging"

If we, in this Nation, ever hope to establish an adequate retirement income maintenance program, we will have to resolve medical cost problems that otherwise will remain an intolerable drain upon the limited resources of the elderly and forestall every alternative in providing adequately for the economic security of the aged.

This was the frame of reference for the Committee's consideration of health aspects, provided by Senators Williams and Muskie in their foreword to the working paper prepared by a distinguished advisory committee of health experts.

Repeated here are the Committee's recommendations related to health aspects growing out of the 2-year study of the Economics of Aging:

Prospect of a National Health Insurance Program

The Committee on Aging has said, in recent annual reports, that one way to assure acceptance of a national health insurance program for all age groups is to perfect the Medicare program and to apply the lessons learned from this program to more general coverage.

In addition, this Committee suggests that appropriate congressional units consider the possibility of establishing—on whatever basis is most appropriate and consistent with the jurisdictional responsibilities of those units—a task force which will, within

a specified time period (such as 6 months) assemble analyses of various proposals, cost estimates of these proposals, evaluations of the adequacy of existing technical knowledge about subproposals designed to increase the efficiency of our health care delivery system, and other issues closely related to the fundamental questions which will face any legislator who considers national health insurance, namely, (A.) "What will the new demands for service be under widely extended public insurance coverage, and (B.) what more must be done to assure that our medical resources are capable of meeting that demand?"

Urgently Needed Steps To Improve Medicare

We must also expand and improve Medicare, particularly by including prescription drugs essential for the treatment of the chronically ill, and by covering disabled beneficiaries.

It is imperative that Parts A and B of Medicare be merged and that costs of Part B be financed through taxes on rising payrolls and general revenues rather than from premiums paid by aged persons living on low fixed incomes.

The 92d Congress should give serious consideration to removing the requirement of 3 days of prior hospitalization as a condition for extended care benefits.

Medicaid Should Be Improved—Not Weakened

We therefore recommend that the 92d Congress retain the provision in the Social Security Act which would require States to have comprehensive Medicaid programs by 1977 and that other necessary steps be taken to improve the Medicaid program.

Translating Health Care Into Social Care

We recommend that an intensive educational campaign be conducted toward the acceptance of the concept that programs to provide "a proper environment in which to regain health" are valid health expenditures which will, in the last analysis, save public funds and prevent needless drains upon the fixed income of elderly individuals.

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON HEALTH

Many of the recommendations expressed by the participants in the White House Conference on Aging in 1961 are still valid, if largely unfulfilled, today. Agreement was reached on the need for a "broad spectrum of institutional facilities," on the importance of health maintenance and availability of care at home, on coordination of services, standard-setting providers of care, and much else.

But, if there still remains a great deal of work to be done in reorganization of medical resources and personnel, the last decade has been of crucial importance as one which has set the stage, at last, for far-reaching reforms that could assure high-quality health care for all Americans despite differences in income, geographic location, and race.

Medicare and Medicaid have served as experiments from which hard lessons can be learned. Those lessons, even those that now seem negative, can be made to work for the benefit of all Americans, including the elderly.

I. RECOMMENDATIONS IN 1961

Conferees charged with formulating recommendations on Health and Medical Care, including Institutional Care, developed their proposals in relation to specific areas of care. For use in assessing achievements, there is no overall policy statement on goals and no recommendation dealing with the importance of improving the health care system as a coordinated whole so that it can provide a continuum of optimum care.

The conferees dealing with various health care areas emphasized these points:

Institutional Care.—The broad spectrum of institutional facilities that is essential for proper health and medical care, should be provided through orderly planning using the local area as the planning base. No needed care should be denied because of inability to pay, nor should the financing mechanism create impediments to the proper utilization of facilities, including the home.

Conferees considering medical care recommended encouragement to voluntary health insurance and further implementation of existing public assistance programs, saying "compulsory health care inevitably results in poor quality health care."

Care at Home.—Recognizing the need for strengthening and greatly extending services that permit the older person to be cared for at home, this group recommended that additional emphasis be given to research and evaluation in the organization and delivering of patient care services in the home in order that such services may be systematically modified to achieve the twin goals of effectiveness and economy.

Health Maintenance.—This group came closest to an overall policy statement by including, among its specific recommendations for strengthening preventative and health maintenance programs, the following: "Health care should be made available without barriers and with preservation of the dignity of the individual."

Mental Health.—Emphasis here was placed on including the mentally ill in all programs for health care, with their services provided through the same agencies that serve others in the community.

Organization and Community Services.—These conferees stressed the importance of continuity of care and coordination of services identifying as a major obstacle "the fractionation of health services away from agencies concerned primarily with health matters." Their recommendations included: "Federal, State and local programs in the field of health and medical care should be administered by medically oriented agencies."

II. THE RECORD SINCE 1961

Overshadowing all else during the past decade was passage of Medicare and Medicaid as Titles XVIII and XIX of the Social Security Amendments of 1965. But, in recognition of the need for greater cohesiveness in Federal health programs on one hand, and greater flexibility for local planning on the other, the Congress enacted the "Partnership for Health" program in 1966 (substantially amended in 1967 and 1970) and the Regional Medical Program in 1965. The decade also brought several other congressional enactments meant to deal with individual problems such as medical manpower shortages and upgrading of the Community Mental Health Center program. These and other programs, however, were under intensive evaluation as the 1970s began, and as the Congress and the Executive Branch seemed to be on the verge of formulating vast changes in policies and programs.

III. ISSUES IN 1971

The 1971 conferees will convene at a time of heightened demand for comprehensive national health insurance for our total population, not, as in 1961, for just a limited medical care program for the aged segment of the population. During the last half of the decade, since the enactment of Medicare and Medicaid, we have learned that it is not enough for the Government to simply provide a mechanism for the financing of health costs; Government also has responsibility for assuring that high quality services will be delivered in an efficient, economical manner. We have also learned the value to the patient of coordinated and continuous care, and that fragmented care can greatly increase costs because of duplication and inappropriate use of facilities and manpower. Increasing attention is being focused on Health Maintenance Organizations with their potential for holding down costs at the same time that optimum and early care is provided. Greater awareness of the need for planning has been accompanied by recognition of the importance of broadening the planning base beyond the local communities in the entire region, with special attention to rural areas and to the ghettoes in which so many older people are concentrated.

Thus the atmosphere in which health care will be considered at the 1971 Conference is totally different than in 1961. Regardless of the specific issues which will be considered, the conferees clearly have a formulated recommendation on coordinated health care, broadly defined to encompass social care, and with the recommendations the aged group formulated in relation to the health needs and resources of the entire Nation.

CHAPTER III

HOUSING: RECALCITRANT PROBLEMS AND NEW PROMISE

Housing for older Americans during 1970 was directly affected by what can only be described as an industry-wide depression.

Builders, faced by the highest interest levels in a century, could not afford to borrow for land and building supplies. Consumers could not find mortgages at prices within their grasp. New building starts numbered only 1.45 million, far below the 2.6 million-unit goal set by the Congress 2 years ago.

In short, the severe housing shortage documented by the President's Committee on Urban Problems in 1968 worsened during the past year.

As a consequence—while there is a conspicuous absence of good hard data about housing needs of older Americans—what little data is available strongly suggests that far too many elderly live in too many substandard dwellings.

In 1970, the Congress extended several existing housing programs for the elderly. One such extension was an eleventh-hour rescue of Section 202, which provides direct loans to nonprofit sponsors of housing for the elderly and handicapped. In addition, the 1970 Housing bill authorized congregate meal service facilities in public housing, thus closing a major gap in that program.

I. HOUSING NEEDS OF THE ELDERLY

Logic and the consensus of opinion both support the premise that far too many older Americans live in substandard or unacceptable housing. While it is known that household costs—shelter, utilities and repair—constitute the most expensive item for the aged (about 34% of the Bureau of Labor Statistics retired couple's budget), it is not known with anything like precision how many live in inadequate housing. Virtually all the studies available today are projections from the 1960 Census which revealed that 30 percent of all households headed by persons aged 65 occupied housing that was dilapidated, deteriorating, or lacking some facilities. This figure represents about 2.8 million substandard units.[1]

The 1970 Census abandoned the collection of data regarding "substandard housing" because it was thought that the term was too subjective; accordingly, the new Census will not provide a precise up-date of the 1960 statistics. Regrettably there are few other broad-range studies which have considered the housing needs of the elderly. The most notable of these surveys is the report in 1968 of the Presi-

[1] 1960 Census statistics quoted by Marie C. McGuire, Special Assistant for Problems of the Elderly, HUD, in her 11/6/67 speech in Charleston, W. Va., p. 4 of the printed text.

dent's Committee on Urban Problems. The report entitled, "A Decent Home" sets out in detail the housing needs of the poor. Some extrapolation of statistics is possible, based on the rationale that the elderly represent 20 percent or 5 million out of the Nation's 24 million poor.[2]

The Committee noted, "There is an immediate and critical social need for millions of decent dwellings to shelter the Nation's low income families." [3]

In answering the question of how many units were needed, the Committee called for 6 to 8 million federally assisted units for the poor to be built in 10 years or a building rate of 600,000 per year.[4]

Since the elderly constitute 20 percent of the poor their need can be projected as between 1.2 and 1.6 million units or a minimum building rate of 120,000 units a year. By contrast only 41,000 units could be identified as approved or committed for the elderly poor last year.[5]

Another method of anticipating present housing needs is by projecting the 1960 Census statistics. Recent evidence indicates that 14.2 million units were built in the 1960's, which was 6 percent less than the amount built in the 1950's, With total housing building rate in decline by 6 percent and since the number of elderly has increased from 16.5 million in 1960 to 20 million in 1970, it is logical that the elderly continued to need at least the same level of housing as in 1960 when 30 percent lived in substandard (2.8 million) units.[6]

If 30 percent of the elderly continue to live in substandard housing then 6 million today need decent housing. Assuming that there are two seniors per dwelling (which is unrealistic since a majority of those over 65 are single or widowed) a minimum of 3 million units would be needed which compares favorably with the 2.8 million units needed in 1960. In all probability, however, the housing needs of the aged have risen since 1960, largely because government programs accounted for only 336,000 units in the last 10 years.[7]

Certainly, none of these housing projections is very satisfactory and the need for some firm data on the housing concerns of the elderly is obvious. There are, however, a few facts that are known about the consequences of homeownership as it relates to the aged. These facts are a result of hearings conducted by the Senate Special Committee on Aging into Homeownership Aspects of the Economics of Aging. The study was brought about by numerous contacts received by the Committee from seniors who reported having to pay from 20 to 50 percent of their yearly incomes on escalating real estate taxes.

A. Information on Homeownership

The facts the Committee assembled outline a very real and unfortunate dilemma described as a lack of housing mobility. The Committee hearings disclosed:

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[2] Report by the Senate Special Committee on Aging, Economics of Aging: Toward A Full Share in Abundance, pp. 8 and 50.
[3] "A Decent Home," Report by the President's Committee on Urban Problems 1968, p. 8.
[4] Report cited in footnote 3, p. 40.
[5] Department of Housing and Urban Development's Annual Report to the Senate Special Committee on Aging, reprinted in the Appendix, p. 196.
[6] Washington Post, February 8, 1971, p. A2.
[7] Report cited in footnote 5, p. 205.

—For most older Americans their home is their only asset.
—Two-thirds of the elderly own their own homes and 80 percent of these are free and clear of mortgages.
—One half of these seniors have a $25,000 equity or more in their homes.
—Housing continues to be their largest single expense (34% of BLS retired couple's budget)—in a very real sense they are "house poor."
—The elderly often have reduced physical abilities and are not readily able to maintain their homes as before. These services must be volunteered by friends or purchased.
—They tend to live in the older blighted sections of town. The percentage of seniors in Model Cities target areas, for example, ranges from 10 to 50 percent.
—Their small retirement incomes and the physical inability to make inquiries of units for rent sharply constricts their choice of alternative rental housing.
—Their short life expectancy, lack of funds, and the general unavailability of sympathetic government programs has prevented them, in large measure, from becoming home purchasers.
—Real estate taxes continue to escalate as States struggle to find additional revenues.[8]

In summary, evidence available indicates that most seniors own their own homes—homes which once represented security in earlier life are now expensive and difficult to maintain and many would gladly move to smaller quarters if they could find acceptable alternative housing.

B. "Single-Occupancy" and Institutionalization

The number of elderly living alone in old hotels or other rundown rental housing is most difficult to measure. In many ways these occupants have the worst of housing worlds. Many are without friends or family and they look for quarters which are as inexpensive as possible. These buildings are often unsafe and without plumbing and other facilities.

The number in institutions is easier to enumerate. Most estimates indicate at least 1 million older Americans are housed in nursing homes and mental institutions. While the adequacy of the housing and the care received by these patients is a significant question—an even more troublesome question is:

How many elderly could be housed elsewhere if they had some other place to go? There are few firm answers to this question. Some studies indicate that as many as 26 percent of the individuals in mental institutions could be released if they had some other place to go.[9]

A few things are clear: There is not enough housing for the aged; much of what is available is unfit for habitation; and that older Americans suffer from a lack of housing mobility.

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[8] See Homeownership Aspects of the Economics of Aging; summarized in Developments in Aging 1969, p. 71–73.
[9] Marie C. McGuire (footnote 1) quoted in her 9/16/69 speech in Durham, N.C.

II. CONGRESSIONAL ACTION AND THE 1970 HOUSING ACT

In 1970 the Congress enacted a number of items of interest to the elderly, including the Uniform Relocation Act of 1970 and several provisions within the 1970 Housing bill, including the authorization for new cities and enabling legislation for congregate living facilities. But the highlight of this session came when Senator Harrison Williams—with the support of Senators Frank E. Moss, Winston Prouty, and John Pastore—acted to save the Section 202 program.

A. Rescue of Section 202

FHA Section 202 of the National Housing Act authorizes a program of direct loans from the Federal Government to nonprofit sponsors who desire to provide housing for the elderly and handicapped. Sponsors borrow up to 100 percent of project cost and repay the loan with 3 percent interest over 50 years.

Senator Moss, chairman of the Subcommittee on Housing for the Elderly, took the floor of the Senate on July 16 to protest the proposed phase-out of the direct loan program in favor of FHA Section 236 which requires borrowers to go to the private money market for loans with the Government assuming all but 1 percent of the interest on such loans.

> The 202 program has been one of the most effective and efficient of our housing program. In fact, some people say its very success might have been its undoing. Nonprofit sponsors had learned the procedures and had begun to develop a sizable volume of projects until the program was sharply interrupted by HUD policies announced by the Nixon Administration.
>
> The Administration has been consistent in its opposition to direct loans issued by the Government. The rationale is that through direct loans the Government is placing itself into competition with private lending establishments.[10]

The Banking and Currency Committees of the House and Senate included strong language in the Housing Act of 1969 to the effect that the Section 202 program should be continued and authorized $150 million for this purpose.[11]

The Administration, however, did not request any funds for Section 202, and no funds were written into the 1969 Independent Offices Appropriation bill for this purpose. The same was true of 1970. When the Independent Offices Appropriation bill cleared the House of Representatives in 1970, no funds were included for the direct loan program for the second year in a row.[12]

Senator Williams interceded when the bill reached the Senate floor and saved the program from almost certain extinction. The Williams amendment added $25 million in the Senate-passed bill for 202. In

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[10] Speech by Senator Frank E. Moss, Survival of FHA Section 202, Congressional Record, July 16, 1970, p. S. 11559.

[11] For more chronology in the fight to save the 202 direct loan program see Developments in Aging 1969, p. 73.

[12] For some possible insight on FHA abandonment of Section 202, see speech by FHA Commissioner, Eugene Gulledge, Appendix 3, p. 317.

compromise with the House, the amount was reduced to $10 million but further language was added to the bill stipulating congressional intent that this program continue and that the $40.7 million in the revolving fund representing 202 repayments be spent to provide urgently needed housing for those that are elderly and handicapped.[13]

Another important byproduct of the fight to save this program was the congressional declaration that 10 percent of all funds allocated for Section 236 (an interest subsidy section for all age groups aiding in the construction of rental housing) should be spent for the development of housing units for the elderly and handicapped.[14]

HUD and FHA should reinstitute the 202 program as it functioned through 1968. Transfer to Section 236 by sponsors after initial application should be permissible but not mandatory. The Congress should appropriate the $150 million yearly authorized for this program to provide needed housing for the elderly.

B. Congregate Housing

A major breakthrough with potentially far-reaching implications for the Nation's elderly was incorporated in the 1970 Housing Act, signed into law on December 31, 1970. The important provision would broaden public housing coverage to include central dining facilities for aged individuals who are unable to cook for themselves or who prefer this type of accommodation or services. For these persons, this measure can provide an important alternative to unnecessary and premature institutionalization. Moreover, the new law authorized Federal funding for congregate housing for the elderly, handicapped and displacees under the Section 236 interest subsidy program for apartment units.

This major breakthrough was made possible by the introduction of S. 4154 by Senators Williams and Moss.

Senator Williams explained:

> A major problem affects those older persons who must leave their homes and move into nursing homes—not because they are ill but only because failing energy often prevents them from shopping for food or cooking. Many potential applicants for public housing fail for this very reason.
>
> My bill would help make it easier for these individuals to live at home, rather than in a nursing home. It would do this by broadening public housing coverage—not only to provide suitable residential living but also services for central dining facilities for the poor elderly who cannot cook their own meals.[15]

Senator Moss agreed, stating:

> Senior citizens should not have to enter a nursing home simply because they are not readily capable of preparing their own meals. They also are deprived of the socialization inherent in dining together.[16]

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[13] Senator Harrison Williams, Congressional Record, Dec. 7, 1970, p. S. 19523.
[14] Footnote 13, Colloquy between Senator Williams and Senator Pastore.
[15] Senator Harrison Williams introducing Senate Bill 4154, Congressional Record, July 30, 1970, S. 12430.
[16] Speech by Senator Frank E. Moss in introducing S. 4154, Congressional Record, July 30, 1970, p. S. 12431.

The new congregate housing provisions for the elderly under the 1970 Housing Act should be fully funded and promptly implemented.

With these innovative approaches, more urgently needed housing can be built for the aged—not merely to "store" them, but to restore them to a more active life in their communities and reduce costs of care that might otherwise be required.

C. Other Provisions of the 1970 Housing Act

The compromise $2.9 billion 1970 Housing bill [17] with the notable exception of the provision for congregate living facilities, largely extended existing programs. However, other provisions of interest to the elderly include:

—Section 104 authorizing the Secretary of HUD to compensate owners for serious defects in homes purchased under the Section 235 program as it applies to existing housing.

—Section 113 which raises FHA loan limits for mobile homes from $10,000 to $15,000 in the case where a mobile home is made up of two or more modules.

—Section 208 reaffirms the 1969 Housing Act in placing a rent ceiling of 25 percent of tenants' income in public housing, defining in detail the word "income" and ending any speculation as to what was the intent of the 1969 legislation.

Title VII of the Act provides for a new program to aid community growth and community development. A five-member HUD Community Development Corporation was created to run loan and guarantee programs for new communities in both the inner-city and suburban-rural areas. Up to $240 million in loans is authorized; and some $500 million is provided in guarantees for bonds, debentures, or other obligations incurred nationally by public or private developers of "new communities". Additionally, $5 million is authorized by planning subsidies.

The new communities proposal is potentially of great value to the elderly and the Department of Housing and Urban Development should carefully monitor developers so that ample and appropriate provisions are made for the elderly within the new communities.

D. The Uniform Relocation Act

Serious problems created by the displacement of citizens by government action—and appropriate methods for compensating these Americans uprooted to make room for highways and other public improvements—has been under consideration and study for some time. The Senate Special Committee on Aging early learned that a substan-

[17] The 1970 Housing Act, P.L. 91–609, Congressional Record, Dec. 17 ,1970, p. S. 11992.

tial number of these dislodged persons were elderly.[18] The Committee also discovered that the aged are "more vulnerable to the shocks and losses attendant on relocation" than their younger counterparts.[19]

In 1970 corrective action was taken when S. 1, introduced by Senator Edmund S. Muskie was enacted into law. The Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 [20] provides for uniform and equitable treatment of persons displaced from their homes or farms because of Federal or federally assisted programs; it also provides for uniform and equitable land acquisition policies.

The bill provides instruction to the more than 50 Federal, State, and local agencies utilizing Federal funds to find replacement housing for homeowners, tenants, and businesses affected by proposed projects. Given the unavailability of other alternatives the agencies are authorized to finance housing construction.

The Act provides the following benefits:

—Individuals forced to move could collect up to $300 in moving expenses.
—Displaced businessmen and farm owners could receive from $2,500 to $10,000.
—Homeowners may be compensated up to $15,000.
—Tenants who were displaced will be eligible for $1,000 annually for 4 years in rent supplements.
—In order to encourage homeownership the legislation provides at least a $2,000 downpayment on a home for displaced individuals.

Other provisions of the Act establish policies to guide all Federal and federally assisted agencies in negotiations with owners for the acquisition of real property for public use. This section of the Act guarantees the individual separated from his land by government action that he will receive in compensation not less than the appraised fair market value.[21]

E. Appropriations for HUD in Fiscal Year 1971

The Independent Offices Appropriation bill, 1971, containing the funds for the Department of Housing and Urban Development, passed the Congress on December 7, 1970 [22] and made available $3.343 billion for housing, almost doubling last year's appropriation of $1.869 billion. The increase reflects a $1.2 billion appropriation for urban renewal, about a billion dollars more than last year.

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[18] One of the earliest and most formidable attempts to bring this problem into focus was the series of hearings held by the Senate Committee on Aging in 1962. These hearings were conducted by Senator Harrison Williams, then chairman of what was called the Subcommittee on Involuntary Relocation of the Elderly. These hearings pointed out the lack of a reasoned approach to the problems of relocation; the lack of suitable housing alternative for the displaced. They also indicated that the elderly were to be found by and large in the older sections of the central city—prime areas for urban renewal; problems of the black elderly in this regard were described as particularly acute:

Subcommittee on Involuntary Relocation of the Elderly:
Part 1. Washington, D.C., Oct. 2, 1962.
Part 2. Newark, N.J., Oct. 26, 1962.
Part 3. Camden, N.J., Oct. 29, 1962.
Part 4. Portland, Oreg., Dec. 3, 1962.
Part 5. Los Angeles, Calif., Dec. 5, 1962.
Part 6. San Francisco, Calif., Dec. 7, 1962.

[19] Preface to the book, Relocation in Urban Planning from Obstacle to Opportunity, by Paul L. Niebank and Mark R. Yessian, University of Pennsylvania Press, 1968.

[20] Public Law 91-646.

[21] Congressional Record, p. S. 20458 (Dec. 17, 1970).

[22] Appropriations for Independent Offices 1971, Public Law 91-556.

The Model Cities program was funded at the $575 million level for the second year in a row while most programs of direct interest to the elderly received slightly increased appropriations. The low-rent public housing program jumped from $473 million in 1970 to $654 million in 1971. Section 235, which provides interest subsidies to low- and moderate-income homebuyers, received an increased appropriation from $90 million to $130 million in 1971. Section 236 providing interest subsidies to development of rental housing received $135 million, up from $85 million in 1970.

Section 202, direct loans to nonprofit sponsors providing housing for the elderly and handicapped received a $10 million appropriation; no funds were appropriated for this program in 1970. The rent supplement program received $46 million; approximately a $4 million cut from 1970.[23]

III. HUD STATUS REPORT ON EXISTING PROGRAMS

The Department of Housing and Urban Development now administers 21 programs dealing directly or indirectly with the needs of the elderly. In its report to the Senate Special Committee on Aging (see Appendix 1, p. 196) the Department takes pride in the fact that in the 10 years, 1960–70, the number of federally subsidized units specifically designed for the elderly has increased from 1,100 units in 1960 to a cumulative total of 180,000 units in 1970. The increase is the result of two programs according to HUD, low-rent public housing and the Section 202 direct loan program.[24]

With this new evidence of the importance of Section 202 it is significant that HUD continues to write about this program in past tense.

Other parts of the HUD report happily are more hopeful. One of the most hopeful programs is "Operation Breakthrough" which was designed to develop new concepts in housing which could easily and inexpensively be reproduced. HUD engaged the National Bureau of Standards to provide design guidelines aimed at reducing home accidents, meeting the special needs of the seniors and minimizing the possibility of criminal activity. These criteria are being used as architectural guidelines by "Breakthrough" producers who it is estimated will provide 2,800 new units for the elderly.[25]

Low-rent public housing continued to be the largest housing program addressed to meeting the needs of older Americans, adding 33,481 more units in 1970 for a cumulative total of 282,757 units. The Section 202 direct loan program contributed 398 units for a cumulative total of 45,106 units; FHA Section 236 counted 7,739 units in 1970 and a cumulative total of 9,883 units. FHA Section 231 provided 88 new units in 1970 for a cumulative total of 43,657.[26] The rent supplements program providing rent reduction for tenants under FHA Sections 202 and 231 has served over 4,200 persons or families in 162 projects with rent supplements totaling $3.7 million per year.[27]

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[23] Congressional Record, Dec. 7, 1970, p. S. 19559.
[24] Report cited in footnote 5, p. 200.
[25] Report cited in footnote 5, p. 200.
[26] Report cited in footnote 5, p. 206; see also Table on p. 205.
[27] Report cited in footnote 5, p. 207; see also Table on p. 205.

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON HOUSING

The 1961 White House Conference on Aging, acting on the information provided by the 1960 Census that 30 percent of America's older Americans live in dilapidated or otherwise substandard housing, recommended a coordinated approach to restore or replace these unacceptable 2.8 million senior occupied units. Primary responsibility was placed on the Federal Government by the Conference which called for the massive expansion of Federal mortgage insurance and long-term loan programs.

Unfortunately, the 1971 Conference will find itself under a severe handicap because of the inadequate data reflecting the present housing needs of the aged. The appropriate question for discussion by the Conference would be:

How many older Americans need what kind of housing?

Just as apparent as the shortage of data is the fact that the recommendation of the Conference for a massive expansion of Federal mortgage insurance and long-term loan programs was never realized. The Section 202 program, Section 236, and the combination of 207 and 231 have produced only about 100,000 units for the elderly in 10 years or a building rate of 10,000 units a year.

I. RECOMMENDATIONS IN 1961

The 1961 Conference indicated the importance of the question of adequate housing for the aged stating its belief in the relationship between "adequate housing and the happiness, health and welfare of the individual and the security of the Nation as a whole."

The White House Conference recommended:

1. More housing of every type so the elderly would have a wide range of choices and easy mobility from one type of housing to another.
2. Proper planning of units from the point of view of design and placement within the community mainstream.

As the primary means for reaching these goals the Conference called for the massive expansion and liberalization of Federal housing programs naming in particular: mortgage insurance and long-term loans; the public housing program; research and the Section 202 direct-loan program.[28]

II. THE RECORD SINCE 1961

In the decade of the 1960's, counting both public and private housing, approximately 14.2 million new dwelling units were built (6 percent less than the number of units added in the 1950's).[29] While the number of private units built for the elderly in the same period is unavailable, the number of federally assisted units built for older Americans comes to 336,000 or a rate of 33,600 units per year.[30]

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[28] The 1961 White House Conference on Aging, Basic Policy Statements and Recommendations, U.S. Senate Special Committee on Aging, p. 67–68.

[29] Washington Post, Feb. 8, 1971, p. A2.

[30] Report by the Senate Special Committee on Aging, Economics of Aging: Toward a Full Share in Abundance, pp. 8 and 50.

How does this compare with the number of units for seniors considered needed in 1961?

The 1961 Conference had access to the information provided by the 1960 Census that 30 percent of units occupied by those over-65 (or some 2.8 million units) were substandard—that is to say dilapidated or lacking some essential facilities.[31]

With the total number of new units built in the 1960's set at 14.2 million it is unreasonable to believe that 2.5 million of this number were private housing for the aged. This number taken together with the 336,000 federally assisted units would have been necessary to reach the stated 1961 need of 2.8 million units.

What follows is an analysis of the contribution of the various HUD (federally assisted) programs toward meeting the goals announced by the earlier White House Conference.

LOW RENT PUBLIC HOUSING

A specific recommendation from the 1961 Conference called for the expansion of this program to meet the needs of the poor. Appropriations for this program were $145 million in 1961 and the Congress has fixed the figure at $654 million for 1971, an increase of 400 percent. While this program was designed for the poor it recognizes that the elderly constitute a large segment of the poor. Last year the program provided over 33,000 new units for the elderly for a 10 year total of 282,757 of the total of 336,000 federally assisted units for older Americans.[32]

RENT SUPPLEMENTS

The rent supplements program created in 1965 was designed to help low-income families and individuals who are either elderly, handicapped, or displaced by government action. Appropriations started at $12 million in 1966 and number $46 million in 1971; 162 projects and 4,200 individuals or families have been served. Under this program payments are made to certain owners of private housing projects, and tenants are required to pay 25 percent of their income for rent.[33]

Rent supplements and low-rent public housing represent the Federal Government's efforts to provide housing for large numbers of the 24 million (5 million elderly) Americans with incomes below the poverty line. The President's Committee on Urban Problems in its report, "A Decent Home," emphasized the need to do much more indicating the immediate need of 6 to 8 million units for the poor in 10 years or 600,000 to 800,000 units a year. Since the elderly constitute 20 percent of the Nation's poor they need 120,000 to 160,000 housing units per year.

MORTGAGE INSURANCE, AND LONG TERM LOAN PROGRAMS

Another major recommendation of the Conference was for the expansion and liberalization of mortgage insurance and long-term loan programs, naming specifically the Section 202 direct loan program.

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[31] 1960 Census statistics quoted by Marie C. McGuire, Special Assistant for Problems of the Elderly, HUD, in her 11/6/67 speech in Charleston, W. Va., p. 4 of the printed text.
[32] Report cited in footnote 5, p. 205; see also Table on p. 205.
[33] Report cited in footnote 5, p. 207; see also Table on p. 205.

Other programs covered by this heading, as it relates to the elderly, are Section 236, and the combination of 207 and 231 programs. Taken together with 202, these programs have provided approximately 100,000 units for the elderly in 10 years.[34] It would be difficult to believe that a building rate of only 10,000 units a year would meet the recommendation for the "expansion and liberalization" of the mortgage insurance and long-term loan programs.

The Section 202 direct loan program was expanded more than any of the other programs providing 45,106 units by itself in 10 years. Under this program, nonprofit sponsors could borrow loans at 3 percent to provide housing for the elderly and handicapped. Loans covered 100 percent of development costs and could be repaid over 50 years. This program had received a cumulative total appropriation of $550 million by the end of 1969 and 345 projects without a failure.[35]

In early 1969 when the new administration announced its policy against direct loans and the replacement of Section 202 by Section 236, an interest subsidy program providing rental housing for all age groups, there was a backlog of some 728 Section 202 applications waiting to be processed. The Congress has made known its intent that the program continue because it was very successful and well received in the community.

Any evaluation of Section 236 must wait further experience. Because of its projection as a successor to Section 202 it has been controversial. It has been well received in the banking community because a sponsor must go to the private money market for his capital. The sponsor will repay the principle and 1 percent of the interest with the Government paying the interest differential to the banking institution. The program has received appropriations of $85 and $135 million and produced 9,883 units for the elderly in 1969 and 1970.[36]

The 231 program, which absorbed the 207 program, is a mortgage insurance program providing nonprofit sponsors with 100 percent financing and limiting profitmaking institutions to 90 percent. This program has been used to purchase and rehabilitate old hotels which are then turned into "Hotels for Senior Citizens" as well as new housing for the higher-income elderly. There were many failures and foreclosures under this program and it is now almost phased out. No new units were produced under this program in 1969 and only 88 units were added in 1970. The combined 207/231 program has produced 43,657 units in 10 years.[37]

Sections 231 and 202 are the only two programs designed exclusively for the elderly. It is imperative therefore that existing flaws in the 231 program be corrected and that 231 along with 202 continue to provide much needed housing for older Americans.

THE QUESTION OF HOMEOWNERSHIP AND HOUSING MOBILITY

The dilemma facing seniors who own their own home and would gladly move to smaller quarters to get away from the burdens of costly repairs and increasing property taxes has been discussed earlier in this

[34] Report cited in footnote 5, p. 205; see also Table on p. 205.
[35] Speech by Senator Frank E. Moss, Survival of FHA Section 202, Congressional Record, July 16, 1970, p. S. 11559; and Developments in Aging, 1969, pp. 73, 213–214.
[36] Report cited in footnote 5, p. 205; see also Table on p. 205.
[37] Report cited in footnote 5, p. 205; see also Table on p. 205.

chapter. What comes through most clearly is that older Americans have limited opportunity to exchange one residence for another. Federal programs facilitating homeownership are in part responsible because they have virtually excluded the elderly from becoming home purchasers. FHA figures show that only 1.1 percent of mortgagors under their program were over age 60.[38] Lenders in the private money market, too, have been reticent to make loans available to seniors because of their shorter life expectancy and reduced incomes.

The exceptions to this Federal ban on homeownership are the new program providing FHA insurance to purchasers of mobile homes [39] and Section 235 which offers a Federal interest subsidy including all but 1 percent of the interest on a home mortgage loan obtained on the open money market. The program assists low- and moderate-income buyers with their purchases of both new and used housing. Early figures from FHA showed a much greater use of Section 235 than of other homeownership assistance programs; about 4 percent of the loans granted in the first operative quarter of this program involved heads of households 60 or over.[40]

As early as July 31, 1970, Representative Wright Patman charged that the Federal Housing Administration under this program had been permitting real estate speculators to sell substandard homes at inflated prices receiving as much as a 150 percent markup.[41] The charges intensified in December and George Romney briefly withdrew the portion of the program which applied to existing housing. Earlier in the year the other part of 235 which permits the purchase of new housing came under attack for poor workmanship, shoddy materials, inadequate government supervision, and poor site planning.[42] Section 235 received an appropriation of $90 million in 1970 and $130 million in fiscal year 1971.[43]

Older Americans continue to have limited opportunities to change their housing to suit their needs. The avenue of home purchase in later life is virtually blocked with the exception of mobile homes and some 235 purchases; this problem is aggravated today when apartments are in short supply.

With apartments generally showing only a 5 percent vacancy rate and apartments on the eastern corridor showing only a 2.8 vacancy rate seniors had little opportunity to find or exchange housing.[44] They have to compete for these vacant units with their younger counterparts who are more mobile and better off financially. In times of severe shortage the elderly are the ones who are forced to accept the run-down apartment that would otherwise stand vacant. The irony here is compounded.

Recent studies have begun to focus on the problems of abandoned and vacant buildings which lie empty and unused in the core areas of the central city. It has been estimated that there are over 38,000 such units in New York, 18,000 in Philadelphia, 13,000 in Detroit and whole

[38] Homeownership Aspects of the Economics of Aging, U.S. Senate Special Committee on Aging, July 31, 1969, p. 758.
[39] Developments in Aging 1969, p. 76.
[40] Homeownership Aspects of the Economics of Aging, U.S. Senate Special Committee on Aging, July 31, 1969, p. 758.
[41] Washington Post, July 31, 1970, p. A.1.
[42] Washington Evening Star, August 14, 1970, p. A.1.
[43] Appropriations for Independent Offices 1971, Public Law 91–556.
[44] Washington Post, Robert J. Samuelson, March 1, 1970, p. A.1.

blocks lie deserted in the Anacostia section of Washington.[45] Some of these units, forgotten and discarded like many of our elderly, could be made to serve the critical need for housing with a moderate amount of care and repair.

Although present HUD housing programs today have shown considerable progress in locating the elderly within the community mainstream and have increased the number of units designed specifically for the elderly from 1,100 in 1960 to 180,000 [46] in 1970, higher priority must be given to these questions of planning and design in future years. Federal commitments for housing research continue to be unimpressive with only $30 million allocated in 1970 at a time when HUD is attempting to implement the most impressive and significant research program in its history called "Operation Breakthrough." "Breakthrough" will provide approximately 2,800 units for the elderly.[47]

III. ISSUES IN 1971

The following recommendations are offered for the consideration of the 1971 White House Conference.

That the 1971 White House Conference on Aging call for a major study of the housing needs of older Americans in order to determine how many need what kind of housing.

The Conference urge the Congress to provide the increased funding necessary to greatly expand existing housing programs at least to the point of providing 120,000 units for the elderly a year. Particular emphasis should be placed on the need to continue the FHA Section 202 program which serves middle-income elderly with units specifically designed for their special needs.

The Conference recommend that sponsors undertake to incorporate nursing care units within an overall plan looking toward the creation of "campuses for the elderly" which would supply the full spectrum of their housing needs.

HUD should undertake a broad consumer information program to acquaint older Americans with the Federally assisted housing programs available to them.

That there be created a U.S. Government corporation to trade, buy, rent, sell and renovate residential property for senior citizens.

Federal matching funds should be made available to encourage the creation on the State level of volunteer or other rehabilitation and repair programs for senior occupied housing.

The States undertake legislation to require, and that they enforce, minimum safety standards with regard to boarding houses and residential hotels occupied by the aged.

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[45] Legal Problems Affecting Older Americans, Hearings by the Senate Special Committee on Aging, St. Louis, Mo., Aug. 11, 1970, p. 86.
[46] Report cited in footnote 5, p. 196.
[47] Report cited in footnote 5, p. 200.

CHAPTER IV

INCREASING CONCERN OVER NURSING HOMES

1970 proved to be a turbulent year for the nursing home industry. In this year fire claimed 32 lives in a Marietta, Ohio, nursing home; a few ordinarily innocuous salmonella bacteria multiplied themselves into an epidemic with 25 dead in a Baltimore home; Ralph Nader and his task force issued a report highly critical of nursing homes; and an Arkansas Congressman worked in several homes in the Washington, D.C., metropolitan area returning to the floor of the House to inform his colleagues of "shocking and appalling" conditions.

More significantly, 1970 was a year of severe criticism for Medicare and Medicaid, the two Federal programs that together contribute more than two out of every three dollars received by the nursing home industry in what is the second most sizable single-purpose Federal health expenditure. The General Accounting Office reported duplicate payments and collection after the death of patients in audits of these programs conducted in California and Maryland. The Finance Committee of the Senate and the Ways and Means Committee of the House indicted these programs as not only too costly but also inefficient. Administrative regulations, imposed retroactively, reduced the size of the Medicare ECF benefit to half of its 1968 size; and efforts to cut Medicaid by $235 million were stalled in the 91st Congress only to be resurrected in the 92d. Against this background are projected several proposals for National Health Insurance, some of which would eliminate or drastically change existing programs in long-term care.

I. THE NURSING HOME "INDUSTRY"

A look at the nursing homes in 1970 reflects the growth of the industry, the increasing numbers of elderly that need nursing services and the tremendously large contribution of the Federal Government to long-term care.

Substantial Federal contribution.—In fiscal year 1969 over $2.5 billion was spent on nursing home care. Medicaid accounted for $1.3 billion and Medicare another $500 million for a total Federal payment of $1.8 billion, ranking second only to hospital contributions as the most sizable single-purpose Federal expenditure on health.[1] Proportionately, the Federal Government pays more of the cost of long-term care than of any other health need.

[1] Task Force Report on Medicaid and Related Programs (1970), Walter J. McNerney, Chairman, HEW, p. 83.
Statistics for calendar year 1970 are incomplete but unofficial estimates indicate that Medicaid in 1970 contributed more than its total of $1.3 billion to nursing homes. Medicare statistics for nursing homes will be lower than $500 million as can be established by comparing the portion of Medicare monies representing benefit payments. In 1968 benefit payments amounted to $340 million and $300 million in 1969. In 1970 benefit payments were cut to $180 million.

In addition, the Federal Government aids nursing homes through other programs. HEW's Hill-Burton program has for years provided "grant-in-aid" for nursing home construction; the Small Business Administration provides loans to nursing homes; and the FHA insurance program has aided in the construction of over 400 nursing homes and 37,000 beds.[2] The Department of Agriculture also assists Medicaid nursing home patients through its commodities program.

Nursing home growth.—From 1960 to 1970 expenditures for nursing home care increased four times over [3] while the number of nursing homes more than doubled, from 9,582 to 22,993, and the number of nursing home beds more than tripled, from 331,000 to 1,099,412.[4]

Number of older Americans in institutions.—Conservatively there are 1 million over-65 individuals in nursing homes and related institutions.[5] In 1969 there were 894,490 elderly in nursing homes alone.[6] Ninety percent of nursing home residents are over 65; one out of three are over 85; the average age is 80 and women outnumber men two to one.[7]

Nursing home personnel.—The total is estimated at 500,000; 43 percent are aides and orderlies.[8] The Department of Labor estimates some 25,000 vacancies in the industry. Greatest shortage is for licensed practical nurses who register a 14-percent vacancy rate. Average wages vary from $5.02 an hour for dietitians to $1.53 for aides and orderlies. The overall ratio of staff to patients is either .6 to 1 or .87 to 1 if full-time and part-time employees are counted.[9] According to the Department of Labor the turnover rate for all nursing home personnel is 60 percent. For aides and orderlies the turnover rate is 75 percent; it is 71 percent for Registered Nurses; 35 percent for Licensed Practical Nurses and 21 percent for administrative and supervisory personnel.

II. MEDICARE–MEDICAID: MOUNTING CRITICISM AND CONTROVERSY

> Long-term care is a neglected and underdeveloped area. Medicaid and Medicare are not efficient and effective mechanisms for dealing with the problem. Major attention has been focused on the problems of medical care at one end of the spectrum and of income maintenance on the other. Overlooked is the special need for long-term care, which is something less than one and something more than the other. Neither Medicare nor Medicaid was designed to deal with it, and the failure to address the problem directly distorts the operations and inflates the costs of the medical-care programs. [10]

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[2] Publication, Survey of FHA Assisted Nursing Homes (1969) p. 1.
[3] Fortune Magazine, January 1970, p. 78.
[4] American Nursing Home Association Fact Book 1969–70.
[5] Senator Harrison Williams, Congressional Record, July 30, 1969, page S. 12430.
[6] *1970 Health Resources Statistics,* National Center for Health Statistics.
[7] Fact Book cited in footnote 4, p. 6.
[8] Nursing Homes and Related Health Care Facilities, U.S. Department of Labor, Manpower Administration (1969), p. V.
[9] Cited in footnote 2, p. 5, see also New York Times, Feb. 16, 1971, p. A. 1 and 27.
[10] Task Force Report on Medicaid and Related Programs (1970), Walter J. McNerney, Chairman, HEW.

A. Dismantling of the Medicare ECF Benefit

In 1969 a series of new regulations diminished the Medicare nursing home Extended Care Facility program. Prior to these new regulations a patient could receive ECF care if he had been in the hospital 3 days, had a physician certify his need of the extension of the kind of care he received in the hospital and had actually received such care. The new regulation, imposed retroactively, required the patient also to have "rehabilitative potential" and to need "skilled nursing" as defined in the new regulations. [11]

In 1970 further regulations were announced, placing the responsibility for physical therapy more and more on the nursing staff and requiring the retroactive evaluation of the salaries of nursing home operators and personnel.

The effect and extent of these new regulations is indicated by comparing that portion of Medicare outlays to nursing home representing benefit payments.

In 1968 the total benefits payment amounted to $340 million and $300 million in 1969, as compared with a total in 1970 of only $180 million in benefits.[12] In effect, the Medicare ECF program has been cut in half.

The reasons for this sharp cutback are a matter of conjecture. It has been suggested that the new regulations represent the thinking of the Nixon Administration since the first of the restrictive regulations was issued in April 1969.[13] Others such as the Finance Committee of the Senate argued that the law had never intended the Medicare ECF program to function at the $340-million benefit level. In fact, the Finance Committee claimed that the ECF program had exceeded its original estimates 10 times over.[14]

Certainly the intent of Congress, when it enacted the ECF law, is open to varying interpretation but it is a fact that over 4,800 nursing homes were participating in the program in 1969.[15] In early 1967 and 1968 the Social Security Administration actively recruited participants for this program, creating a special waiver category "in substantial compliance" to permit the participation of nursing homes who did not meet all of the Medicare requirements.[16]

With this background it would have been more equitable if Social Security had announced its intent to cut back the program and then issued regulations prospectively. The regulations which were announced were given retroactive application to January 1, 1967, the date the ECF program went into effect, which required nursing home operators to pay back sums they had received in payment from patients, many of whom had long since died. Senator Frank Moss and others have criticized these retroactive regulations as raising "serious questions of equity and due process." [17]

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[11] For further detail on the step-by-step dismantling of the ECF program, see Developments in Aging 1969, p. 87–90 and speech by Senator Frank E. Moss, April 10, 1970. Congressional Record, p. S. 5519–5533.

[12] Bureau of Health Insurance, Feb. 2, 1971.

[13] Congressional Record, April 10, 1970, p. S. 5519–5533.

[14] Hearings by the Senate Committee on Finance, Medicare and Medicaid, July 1, 1969, p. 22–23.

[15] Hearings by the Subcommittee on Long-Term Care, Trends in Long-Term Care, Part 8, p. 686.

[16] Nader Task Force Report, Nursing Homes: "The Agony of One Million Americans". Dec. 1970, p. 78–82.

[17] Report cited in footnote 11, p. 87–90.

The pressures of retroactive denials of claims have forced many nursing homes to drop out of the ECF program. The Associated Press reported on Jan. 21, 1970, that 500 had dropped out of the ECF program.[18] (In February 1971, The American Nursing Home Association withdrew its official support from the ECF program and asked its members to reassess their own circumstances before continuing in the program.[19]

By way of reconciliation the Finance Committee proposed in its 1970 Social Security bill that the Secretary of HEW be given authority to set "presumptions" under Medicare.[20] A person with a broken hip, for example, could be "presumed" to be eligible for 20 (or some other number) days' ECF care. This compromise was suggested to prevent retroactive denials and, at the same time, to keep the ECF program under the heading of short-term, semi-acute care, rather than long-term care.

B. "Overutilization" of Medicaid Facilities

One of the major reasons listed by the Finance Committee for the "excessive costs" under Medicare was the overutilization of facilities which implies that patients stayed longer than they needed to, or that they did not need ECF care as defined by the Congress.[21] This same charge of overutilization was leveled at the Medicaid program by Congressman Wilbur Mills, Chairman of the House Ways and Means Committee, in calling for a favorable vote from the House for H.R. 17550, the controversial House Social Security bill of 1970.[22]

THE FIGHT AGAINST 225(A)

Congressman Mills made specific reference to Medicaid overutilization as the justification for section 225(a) of H.R. 17550 which would reduce the Federal commitment to the Medicaid nursing home program by $235 million.[23]

Section 225(a) would have cut by one-third the Federal matching share paid to nursing homes after an individual had received 90 days of care; matching funds would have been cut after 90 days payment for an individual in a mental hospital and eliminated completely after he had received 275 compensable days of care in his lifetime; matching funds to tuberculosis hospitals were to be cut back after only 60 days. At the same time, the section did provide a 25-percent bonus in Federal matching funds if the State elected to treat a patient through its home health services rather than through its institutional system.

In a bipartisan attack, five members of the U.S. Senate Special Committee on Aging opposed this amendment as unfair, problematic and certainly not the way to end the alleged overutilization of Medicaid facilities.[24] Senator Harrison Williams, then Chairman of the Committee on Aging stated:

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[18] Reprinted and quoted in Senator Moss's speech, footnote 11.
[19] Washington Daily News, Jan. 25, 1971, p. A. 1–2.
[20] Section 233 of the Senate version of H.R. 17550, the 1970 Social Security bill.
[21] Hearings cited in footnote 14.
[22] Speech, introducing H.R. 17550, Congressional Record, May 21, 1970, p. 4646.
[23] Speech cited in footnote 22, p. 4648.
[24] Aug. 4, 1970, press release from the Senate Special Committee on Aging, and Congressional Record of same day, p. S. 12705–09.

> * * * What is puzzling is that in the early 60's our hearings were replete with testimony that the States were having difficulty with the financing of long-term or institutional care * * * The States are hard pressed to raise revenues * * * I must say it is a curious kind of revenue "sharing" which the President is proposing in Section 225(a) of the Social Security Amendments * * * the Federal Government intends to cutback support of the program to such an extent that the States again will have to bear the huge financial burden of caring for a segment of the population that has no resources of its own and is in desperate need of shelter, treatment, and care.

Senator Winston Prouty, ranking Minority member:

> The House-passed cutoff provision is based on an erroneous premise that patients in nursing homes do not require inpatient care after 90 days but may be cared for at home. Such a sweeping and general judgment cannot be made by lawmakers; it can only be made on a case-by-case basis by the physician.

Senator Moss, Chairman of Subcommittee on Long-Term Care and author of a 1967 amendment passed to raise standards in Medicaid nursing homes, said that the House-passed cutbacks will make it impossible for improved standards. Instead, the Federal Government "is going to make substantial reductions in its commitment to the field of long-term care."

Senator Vance Hartke, a member of the Committee on Finance, as well as the Committee on Aging:

> It is estimated that New York will lose $105 million, California $20.4 million; and my own State of Indiana estimates a loss of over a million. Compared to the large losses that will be sustained by New York and California, this loss may seem small, but when one considers the condition of most State budgets these days, it means a great deal in terms of services to older people who have no resources of their own.

Senator Edmund Muskie, Chairman of the Subcommittee on Health, addressed himself primarily to the "special problems and needs of the elderly patient population" in mental institutions. Senator Muskie warned that a decrease in Federal matching for care of 33⅓ percent after a 90-day stay could very well cause "a reinstatement of the backward 'snake-pit treatment' of the 19th century."

He added: "If a 90-day limitation is placed on care for these patients, what then will be the alternative?"

The controversial amendment was eliminated by the Senate Finance Committee which adopted, in lieu, a measure authorizing the Secretary of HEW to make selective cutbacks in the Federal matching rates with respect to types of institutional care where adequate professional review and audit activities regarding care are not being effectively applied. States properly carrying out utilization review and audit functions would not be affected by the cutbacks.[25]

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[25] ANHA Legislative Report, Jan. 1, 1971, p. 1.

The Senate version of the Social Security bill even though identical in some respects with the House version was held up in the Senate because of the extended debate on the supersonic transport and the attempted addition of riders concerning revenue sharing and trade restrictions. Accordingly, no conference between the Senate and House was possible even though both the Senate and House has passed a Social Security bill. The controversy over the method of dealing with the alleged abuses under Medicaid was put over to the 92d session. On the first day of the new session Representative Mills introduced H.R. 1, identical to H.R. 17550 of last year.

C. Medicaid in Controversy—Retroactive Denial by a State

In California the Medicaid program goes by the name Medi-Cal but it is the program that pays for medical care for those unable to pay. California pays 50 percent of these costs and the Federal Government the other 50 percent. Total Medicaid payments to nursing homes in California amounted to $160 million in 1968 of which $80 million was paid by the Federal Government.[26]

In California the controversy over Medi-Cal does not stem entirely from the indictment that the program is overutilized or simply that it is too expensive. The program has an image which has been shaped in part by the 1968 report of the Attorney General of the State of California and by subsequent investigations such as the recently released General Accounting Office audit of the State's Medicaid programs. A summary of this July 23, 1970, report by GAO follows below:

> GAO's review revealed weaknesses in the procedures and practices for approving and paying for nursing home care under the Medicaid program in California. Also, no uniformity existed for making determinations on the necessity for nursing home care.
>
> On the basis of GAO's observations of approvals of nursing home care and conclusions of studies by three counties in California that a high percentage (35, 22, and 20 percent) of patients were not in need of such care, GAO believes that Medicaid recipients were receiving nursing home care without adequate determinations that such care was warranted.

In addition, GAO found

—that, in some cases, care was approved for periods after the date of death or discharge of the patients;

—that, in 22 of 260 cases examined, claims were paid for periods after a recipient had died or had been discharged from the nursing home;

—that, in 12 of 76 additional cases examined, nursing homes were receiving full payments under both the Medicare and Medicaid programs for the same days of nursing home care.

> In view of the weaknesses in procedures and practices and the high incidence of questionable payments (34 of 336 cases examined), GAO believes that the results of its review sufficiently

[26] General Accounting Office Audit of California, July 23, 1970, p. 1.

demonstrate the need for corrective measures to strengthen controls over the approval and payment for nursing home care.

In calendar year 1968, about 100,000 Medicaid recipients received nursing home care in California in about 1,250 nursing homes and, in view of the costs of the program, the lack of adequate control over the approval and payment for nursing home care can result in significantly increased program costs.

An aroused public demanded the facts and some improvement in the system. Senator Allan Cranston quickly responded to the public's complaints by calling for a probe of the Medi-Cal system by the U.S. Senate Committee on Finance. Senator Cranston complained that "duplicate billings have been received and duplicate payments made for up to 14 percent of all medical services rendered."[27]

Following his reelection, Governor Ronald Regan by administrative action cut the Medi-Cal nursing home payments some 20 percent. The maximum rate which had been $14 a day (California and Federal Government each paying $7) was reduced to $12.54 and the minimum dropped from $8.83 to $7.35 a day. Significantly, these new regulations cutting the rate of reimbursement to nursing homes were given retroactive effect to the begining of the Medi-Cal program in 1966. In plain terms the Governor asked the industry to return some $45 million dollars to the State or about $3,800 a bed.[28]

In the face of the new regulations and the retroactive denials imposed arbitrarily by the State of California, the California Nursing Home Association recommended withdrawal from the Medi-Cal program effective February 1, 1971. This position was modified in January by the nursing homes which refused to accept for admission so-called heavy care patients discharged from County hospitals. Heavy care patients typically require more effort, time and medical care from the nursing home. Governor Reagan challenged this refusal with an injunction against the nursing home proprietors, and the California Courts are left to unravel the legalities.[29]

D. Report of the Task Force on Medicaid and Related Programs

The McNerney Task Force was requested by the Secretary of HEW in July of 1969 to examine the deficiencies of Medicaid and related programs, and to make recommendations with regard to improving existing legislation and the need for new laws. The position of the Task Force Report focusing on long-term care concluded:

1. Long-term care is a neglected and underdeveloped area.
2. Medicaid and Medicare are not efficient and effective mechanism for dealing with the problems.[30]

The Task Force issued a number of recommendations for improving present programs:[31]

1. HEW should develop a policy which recognizes that long-term care has three elements; (a) residential services (room and board); (b) personal-support services (chronic care, gen-

[27] Senior Citizen Sentinel, Oct. 1970, p. 2.
[28] Senior Citizen Sentinel, Dec. 1970, p. 5.
[29] Los Angeles Times, Jan. 29, 1971, p. A1.
[30] Report cited in footnote 1, p. 83.
[31] Report cited in footnote 1, recommendations of the Task Force are found on page 115.

eral nursing supervision and assistance with daily living), and (c) medical, dental, and psychiatric services when needed.

2. This policy should comprehend that long-term care includes delivery of services in the home, institutions, and to all age groups.

3. Medicaid regulations should add the requirement for activities planning.

4. Medicaid regulations should require that Medicaid patients are visited by a staff member of the welfare department at least quarterly.

5. The extended care benefit under Medicare should be revised and redefined to eliminate confusion and reduce administrative complexity.

6. The Intermediate Care program should continue to be defined as the zone of personal and residential services midway between the Skilled Nursing Home and the domiciliary institution but that ICF regulations should require activity programing.

7. The Skilled Nursing Home program and the Intermediate Care program should be administered through a single administrative structure to provide efficiency and save on costs.

E. The Nader Task Force Report

Consumer advocate Ralph Nader selected seven young ladies from Miss Porter's school in Farmington, Connecticut to undertake a study of nursing homes and associated Federal programs. They worked at their research for over a year reading all available literature, talking with many nursing home experts and with providers and patients. During the summer of 1970, they worked as aides and visited 20 nursing homes in six different States. Their report, a volume of 400 pages was released at the hearing of the Subcommittee on Long-Term Care, December 19, 1970.

In introducing the Task Force at the hearing Mr. Nader commented:

> There is a colossal amount of collective callousness that pervades the society from the organizational to the individual levels. The most intense focus of what has been wrought for old people is the nursing home. The few homes that are humane, competent and mindful of their resident's needs for activity and meaning to their day provide a staggering gap between what an affluent society should attain and what is too frequently the reality for most nursing homes.

The report entitled, "Nursing Homes for the Aged: The Agony of One Million Americans," is highly critical of nursing homes generally and of existing programs. The Task Force issued the following recommendations: [32]

> 1. The waiver requirement which allows nursing homes to participate in Medicare if they are "in substantial compliance" should be eliminated. The waiver should have been only an interim measure and full compliance with all Medicare regulations should be required before nursing homes receive Medicare funds.

[32] Recommendations, Nader Task Force Report, pps. 269–273; members of the Task Force were: Claire Townsend, Director; Elizabeth Baldwin, Janet Keyes, Lallie Lloyd, Catherine Morgan, Patricia Pittis, and Margaret Quinn.

2. HEW should consider rating nursing homes receiving public funds.

3. The Moss amendment calling for medical review (a patient-by-patient evaluation of the quality of care received in the home) should be implemented and enforced.

4. No single interest should be allowed to dominate the boards of licensure which the States are required to establish under the command of the Kennedy amendment calling for the licensing of nursing home operators.

5. That in-service and other training programs be established for nurse's aides.

6. That the Congress should enact legislation making it easier to identify nursing home owners and to hold them responsible for the conditions of a home.

7. Life-care contracts, in which a person signs away his estate to a nursing home in return for care for the rest of his life, should be condemned.

8. The Food and Drug Administration should exercise more control over experimental drug research being conducted in nursing homes to insure meaningful consent of patients or responsible persons.

9. The Federal Government should promote alternatives to the nursing home for the ill elderly, including home health and homemaker services.

10. Nursing homes should provide preventive medicine, rehabilitation and more psychiatric services.

11. Long-term care must continue to be a public responsibility; the Federal Government must take the lead as the States have been reluctant or unable to meet their responsibility to the infirm elderly and private interests, such as the medical profession and the nursing home industry, are substantially in default of their responsibility.

F. Congressman David Pryor and His Efforts To Establish a Committee on Aging in the House of Representatives

Congressman David Pryor of Arkansas took the floor of the House in February 1970 to tell of his experiences working weekends as a volunteer in Washington, D.C. area nursing homes. The Congressman denounced the "commercialization and dehumanization of the aged." [33] In later speeches he denounced the present system of State inspections of nursing homes as a "national farce". He also pointed out that responsibility for nursing homes, Medicare and Medicaid, and other programs for the elderly is splintered among several committees in the House of Representatives.[34] His current proposal, before the House Rules Committee with some 200 additional sponsors, calls for the creation of a Committee on Aging in the House of Representatives to parallel the functions of the Senate Special Committee on Aging in acting as advocate for the interests of older Americans.[35] A House Committee on Aging, the Congressman feels, would unify responsibility and allow more effective monitoring of existing programs particularly in the area of long-term care.

[33] Congressional Record, Feb. 24, 1970, p. H. 1213.
[34] Congressional Record, Aug. 3, 1970, p. H. 7620.
[35] House Resolutions numbered 118–125 and 158–159.

III. PROGRESS UNDER EXISTING LEGISLATION—THE GAP BETWEEN CONGRESSIONAL INTENT AND IMPLEMENTATION

The Social Security Amendments of 1967 (Public Law 90-248) including the amendments of three members of the Senate Special Committee on Aging and its Subcommittee on Long-Term Care constitute the major portion of nursing home regulatory legislation. The amendments, introduced by Senator Moss, had the intent of raising standards in Skilled Nursing Homes under Medicaid; the amendment of Senator Edward Kennedy requires the licensing of nursing home administrators, and the amendment of Senator Jack Miller created Intermediate Care Facilities. But legislation in and of itself is not enough—it must be followed by proper implementation and enforcement by appropriate government agencies.

A. The Moss Amendments, Sections 224 and 234

The first regulations under the Moss amendments were issued by HEW 26 months after the bill was enacted and then only after repeated inquiries by the Senator and oversight hearings called for July 31, 1969, and May 7, 1970. In beginning this second oversight hearing Senator Moss said:

> Nearly 2½ years have passed since the enactment of the Moss amendments and we still can see little practical result from our legislative efforts. Standards for Skilled Nursing Homes were not developed by the time the amendment, requiring States to use them, became effective on January 1, 1969. Six months later, interim standards were published which failed in important respects to be responsive to the law. Despite widespread adverse reaction to these interim regulations, including criticism from a special task force appointed by the Department itself, almost a year went by before improved standards were issued. After months of inaction, they were issued shortly after I announced this hearing.

The standards which were issued April 29 in implementation of one portion of the Moss amendments require that nursing homes under Medicaid have at least one registered nurse on the day shift, in charge of supervision of nursing personnel and distribution of drugs. A minimum of one licensed practical nurse is required, in charge of the afternoon and evening shifts. HEW is committed to establish ratios of nurses and staff per patient; Medicaid nursing homes must be in compliance with the Life Safety Code of the National Fire Protection Association; nursing homes must have the services of dieticians or consultants to supervise preparation of meals for patients needing special diets, and that anyone owning a 10 percent or greater interest in a nursing home must disclose such interest.[36]

Other portions of the Moss amendments implemented with preliminary regulations in 1970 (final regulations followed in February 1971) called for medical review.[37] Medical review contemplates the

[36] Public Law 90-248, Section 234 (28) (A).
[37] Public Law 90-248, Section 234 (26).

evaluation on a patient-by-patient basis of the adequacy of care received by nursing home residents. The State will now be required to assemble a group of professionals, including physicians, nurses, educators, and social workers, who will make the evaluation. Also to be considered is the possibility of rendering care to the patient in a noninstitutional setting. The philosophy of the amendment is that the patient should be in the right place at the right time in view of his needs. Medical review differs from utilizational review which is dollar oriented and asks the question: Is the State paying more money than it should for this patient because he no longer needs hospitalization or skilled nursing services?

Most of the provisions of the Moss amendments have now been implemented with regulations. Another such provision requires the States to set up Home Health Services under their Medicaid programs by June 30, 1970.[38] Still another requires the Secretary of HEW to make an affirmative evaluation to insure that each nursing home fully meets all the State's requirements for licensure before paying out any Federal funds.[39] This latter regulation, unfortunately, was implemented by reference to the definition of "skilled nursing care," the category of care compensable under Medicaid. If a State qualifies for Medicaid funds initially, ergo, the nursing home *must* be in full compliance with all State licensing requirements and the Secretary can release the funds to a nursing home. In reality, what was an affirmative responsibility in law has become a nonregulation.[40]

Significantly, HEW has still to issue ratios of nursing personnel to patients. A judgment of how many nurses are needed by a certain number of patients in a nursing home has been balanced against the availability of nursing personnel and more importantly, the cost to the operator. Clearly, the intent of the amendments is that this issue be resolved in favor of the patients.[41]

More than 30 months have passed by since the Moss amendments were enacted and complete final regulations were published by HEW giving States instructions as to how to comply with the law. The third and most important phase—enforcement of the law—must be judged at a later date. Hopefully the States will show diligence in this compliance.

B. The Kennedy Amendment, Section 236

The Kennedy amendment requires the States to institute procedures providing for the licensing of nursing home administrators. The American Nursing Home Association welcomed this legislation as the first step toward "professionalization." This law requires States to license all nursing home operators, not just those who provide care for Medicaid patients.

As it is implemented, the law requires the appointment by the State of a Licensing Board to oversee licensing procedures. According to statute these boards are to be made up of "representatives of the professions and institutions concerned with the care of the chronically ill and the infirm aged patients."

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[38] Public Law 90–248, Section 224.
[39] Public Law 90–248, Section 234 (28) (C).
[40] Hearings cited in footnote 15, Part 8, p. 639–40.
[41] Hearings cited in footnote 15, Part 8, p. 624.

The interpretation of this section of the law has caused great controversy. Nursing home operators have sought wide representation on these boards, if not outright domination and control. To nursing home operators this is logical. Former President of the American Nursing Home Association, Edward C. Walker explained:

> This is entirely consistent historically when one points to the predominance of physicians, pharmacists, attorneys, dentists and so forth on their own State licensure boards.[42]

On the other side of the coin, advocates such as William R. Hutton, Executive Director of the National Council of Senior Citizens, have charged that the attempts to dominate licensure boards "could well perpetuate abuses the nursing home licensure program was designed to eliminate." [43] Hutton also pointed out that the National Advisory Council on Nursing Home Administration created by this 1967 law had recommended that these boards not have a majority of any one profession.

The Social and Rehabilitation Service of HEW at the request of Mr. Hutton prepared a fact sheet which details that there are 47 States which have complied with the licensure law and established advisory boards; *21 of these have a majority of nursing home administrators.*

Nursing home administrator (NHA's) licensing boards with a majority of nursing home administrators as members, as specified in the law:

1. Alabama	5 NHA's of 9 members until July 1, 1975, then 7 of 11.
2. Colorado	5 NHA's of 9 members.
3. Connecticut	5 NHA's of 9 members.
4. Georgia	7 NHA's of 13 members.
5. Idaho	3 NHA's of 5 members.
6. Illinois	5 NHA's of 7 members.
7. Iowa	5 NHA's of 9 members.
8. Nevada	3 NHA's of 5 members.
9. New Mexico	4 NHA's of 5 members.
10. New York	6 NHA's of 11 members.
11. North Carolina	3 NHA's of 5 members (and 1 nonvoting member).
12. North Dakota	5 NHA's of 9 members.
13. Ohio	At least 4 NHA's of 7 members.[1]
14. Oklahoma	7 NHA's of 9 members.
15. South Dakota	4 NHA's of 5 members.[2]
16. Tennessee	6 NHA's of 9 members.
17. Texas	5 NHA's of 9 members.
18. Vermont	6 NHA's of 9 members.
19. Virginia	4 NHA's of 7 members.
20. Washington	6 NHA's of 9 members.
21. Wyoming	3 NHA's of 5 members.

[1] Ohio—the board as appointed has 5 nursing home administrators out of 7 members.
[2] South Dakota—1 nurse who is administrator or director of nursing services in a nursing home. (Appointed a nursing home administrator with a R.N. degree.)

Source: Social and Rehabilitation Service, HEW, Aug. 29, 1970.

In surveying the data supplied by SRS, Mr. Hutton charged that nursing home operators in 29 States are in a position to dominate State boards, and in another 13 States administrators could dominate their boards with the assistance of one other member who might have a financial interest in nursing homes. In testimony before the Senate

[42] *Nursing Homes*, Aug. 1968, p. 2.
[43] News Release from the National Council of Senior Citizens, Sept. 21, 1970.

Finance Committee he asked for an amendment to clear up this debate emphasizing the need for public representation.[44]

At the May 7, Trends in Long-Term Care hearing, Frank C. Frantz, Chief of the Office of Nursing Home Programs, Medical Services Administration, was asked to give his view of the intent of Congress at the time of the enactment of the Kennedy amendment because he served on the staff of the Senate Special Committee on Aging helping to draft and guide the legislation through the Congress:

> The historical context is that even at that time when the bill was in its formative stage we were hearing the argument about doctors licensing themselves and pharmacists licensing themselves and so on and why not us? We did not think that this was a valid analogy. We did not think that nursing home administration was an established body of knowledge which was the exclusive province of the practitioners. Indeed, in order to establish it as a body of knowledge, it needed the contribution of a large number of other representatives of the health and health service professions.
>
> So, in effect, this language "representative of professionals and institutions concerned with the care of the chronically ill" represented the sponsor's (Senator Kennedy) decision on that argument.[45]

C. The Miller Amendment, Section 250

The Miller amendment authorizes Intermediate Care Facilities—which are institutions licensed by the States and are institutions that provide services beyond ordinary board and room but below the level of Skilled Nursing Homes.

Intermediate Care Facilities undoubtedly fill a need providing States with a new option. In the past, the States had only one choice and that was whether to place an individual in a Skilled Nursing Home or give no care at all. In spite of the obvious benefits of this new option for the States, facilitating placement of an individual in an institution best suited to his needs, there are also dangers. Concerned individuals such as Paul dePreaux, President of the Connecticut Association of Non Profit Homes for the Aged, have feared that State Welfare Departments, in the desire to conserve very scarce funds, might allocate many patients to Intermediate Care Facilities not out of an assessment of their needs but to pay operators the lower costs.

In his July 2, 1970, letter to Senator Moss, Mr. de Preaux charges that the preliminary regulations for Intermediate Care Facilities, announced June 24, 1969, have been obliterated by the final June 10, 1970, regulations. Commissioner Howard Newman of the Medical Services Administration of HEW responded to this letter at the request of Senator Moss. (Letters are printed in the appendix p. 320.)

The Commissioner answered that legal authorities within the various States had questioned the propriety of the issuance of Federal regulations with regard to standards for the Intermediate Care program, and that in HEW's judgement the intent of Congress was for

[44] News release cited in footnote 43.
[45] Hearings cited in footnote 15, Part 8, p. 641.

the States to set their own standards under the Intermediate Care program.

Mr. dePreaux sees this as an abrogation of Federal authority and a serious problem, which is likely to result in lower standards and perhaps the licensure of substandard facilities. He asks the question: Is this (the elimination of Federal Intermediate Care standards) because of incompetence, political expediency or design? and comments: "On the surface it appears that the concern for the welfare dollar has replaced the concern for the welfare patient."

IV. THE EFFECT OF NATIONAL HEALTH INSURANCE PROPOSALS ON PRESENT LONG-TERM CARE PROGRAMS

A. Present Programs

Medicare nursing homes, called Extended Care Facilities, offer the extension of the kind of care the patient needed in a hospital for up to 100 days providing the patient has been hospitalized for 3 days, is specified by a physician to need such services, that he actually receives services within the definition of skilled nursing care and that he has rehabilitative potential. In practice, ECF beneficiaries have received far less than 100 days skilled nursing care. Medicare reimburses the operator for reasonable costs expended.

Medicaid is a Federal grant in aid program administered by HEW in which the Federal Government pays from 50 to 83 percent of the cost incurred by States in providing nursing home care to welfare recipients or those unable to pay for the care they need. Medicaid generally reimburses the operator by giving him a flat fee—perhaps $14 a day to care for a particular patient.

B. Proposed National Health Insurance Programs

1. Senate bill No. 3, the Health Security Act, introduced by Senator Kennedy, provides comprehensive health benefits for Americans of all ages. Title 18 (Medicare) is repealed completely, including the ECF benefit. In its place the bill offers up to 120 days of skilled nursing home care to patients of all age groups. The limit does not apply if the nursing home is owned or managed by a hospital, and payment for care is made through the hospital's budget. Title 19 (Medicaid) will continue only to the extent that it provides benefits exceeding those in the Kennedy bill—principally long-term nursing home care, certain drugs, and adult dental care.

2. The proposal of the American Medical Association as introduced by Senator Hansen (S. 987, Feb. 25, 1971) amends the Social Security Act to provide for medical care and hospital care through a system of voluntary health insurance including protection against catastrophic illness. The Government would pay 100 percent of the costs of health care for the poor, paying the premiums for their voluntary health insurance. Those with higher incomes would be allowed to offset medical costs against their Federal income tax. The bill adds a new Title 20 to the Social Security Act. Title 18, Medicare for the elderly and the ECF benefit are unchanged by this proposal. The present Title 19 Medicaid provision which provides medical care for the poor would be superseded by this proposal leaving

intact that portion of the Medicaid program that provides care for the aged, blind, and disabled.

3. The American Hospital Association's "Ameriplan", provides for regional health care corporations to be set up to take care of the health needs of all Americans from preventive to restorative care. This includes nursing home care. The corporation will make all payments to doctors and providers; it will receive its funds from the general revenues in the case of the poor. It will be supplemented by a payroll tax and those well off would be required to pay part of the costs of their health costs. "Ameriplan" supersedes both Medicare and Medicaid nursing home programs.

4. The Javits bill, S. 836, would add a new Title 20 to the Social Security Act to extend Medicare health coverage to all citizens. There will be no change in the ECF nursing home benefit under Medicare nor any change under Title 19, the Medicaid program.

5. The Administration's proposal, as announced in President Nixon's February 18, 1971, message to the Congress, calls for employers to be required to purchase private health insurance for their employees. A federally subsidized program of basic health insurance (including 30 days of inpatient hospital care or equivalent in ECF) would be provided for low-income families with children. The Medicaid program as it relates to long-term care for the aged, blind, and disabled, would remain the same. Medicare ECF benefits are basically unchanged in spite of suggestions for cost sharing under the program.[46]

V. HEARINGS BY THE SUBCOMMITTEE ON LONG-TERM CARE—THE LESSONS OF TRAGEDY: NEW AND CONTINUING PROBLEMS

The Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging held 10 hearings in 1970. Two of these hearings were devoted to study of the events of the Marietta, Ohio, nursing home fire and another two hearings concerned the salmonella epidemic which claimed 25 lives in a Baltimore nursing home. The investigation of these tragedies revealed significant lessons and many perplexing problems. Other hearings in the series "Trends in Long-Term Care" focused on problems as seen at the State level.

A. The Marietta, Ohio, Nursing Home Fire

The Harmar House Nursing Home in Marietta, Ohio, was a new, fire-resistant, one-story nursing home made of brick and steel with large windows in patients' rooms. Evacuation should have been a simple matter and yet 32 patients died within minutes after the fire started and only three out of a total 46 patients escaped death or disabling injury.[47]

Testifying before the Subcommittee on Long-Term Care, Samuel T. Sides, the State Fire Marshal for the State of Ohio, reported that the patients had died of smoke inhalation and fixed the

[46] Health Message from the President of the United States, Feb. 18, 1971, House Document No. 92–49, p. 17.

[47] Hearings cited in footnote 15, Part 4, p. 351–4.

cause of the fire as most probably a discarded cigarette which burned through the nap of the 100-percent nylon carpeting and ignited the integrally bonded foam rubber padding. The rubber padding, reported the Fire Marshal, had burned with great rapidity, causing intensive amounts of thick, black, toxic smoke. Accordingly, he recommended that, on his experience with this and other fires, all carpet should be banned from all nursing homes and hospitals.[48]

The Senate hearing revealed:

1. That there were few, if any, fire regulations under the Medicare program. Reference was made to Section 405:1134 of the Conditions of Participation in an Extended Care Facility which sets some "guidelines" for the States on fire safety. Unfortunately, this same section also allows these "guidelines" to be applied to existing construction "with discretion in the light of community need for services."

In effect, this section set forth no fire regulations but simply referred States back to their own fire codes. Compliance with State codes was sufficient for purposes of receiving funds from Medicare. (As of January 1971 Medicare's ECF program, by the incorporation of the Life Safety Code of the National Fire Protection Association, has the same minimum fire requirements applicable to the Medicaid program.)

2. State fire codes are often inadequate with regard to the needs of patients in long-term care facilities. In the case of the Marietta fire the Medicare requirements referred providers back to the State statute—which had no requirements with regard to carpets, rugs and curtains.

3. Comparatively little is known about what happens in the course of a major fire. The hearing found fire experts in disagreement—not only as to the cause of the fire but as to the proper procedures to limit its spread. Little is known apparently about what gasses are produced in a fire and what particularly are the consequences of their combination. There is also disagreement as to whether sprinklers, smoke detection devices or some other measure is the best mechanical protection against the fire.[49] The tests currently in use by the National Bureau of Standards to determine the flammability of burning material, from bricks to blankets, are not capable of testing the toxicity of burning gases or of effectively calibrating smoke emission.

4. The Department of Commerce had not, as of the time of the hearing in February 1970, announced any new regulations under the Flammable Fabrics Act of 1967, which was passed to provide the general public with protections against the hazards of flammable fabrics and carpets. Some regulations have been announced subsequently.

5. The importance of fire evacuation procedures, and the practicing of these procedures by the nursing staff, was indicated—since the employees at Harmar House had not practiced fire drills in over a year. (The importance of well trained staff and pro-

[48] Hearings cited in footnote 15, Part 4, p. 424–7 for Fire Marshal's Report.
[49] Hearings cited in footnote 15, Part 5, p. 450–451.

cedures is further shown by reference to the January 1, 1971, fire at the Senator Convalescent Center in Atlantic City, New Jersey, in which 215 patients were removed without death or injury.) [50]

B. The Baltimore Salmonella Epidemic

In the Baltimore epidemic on July 27, 1970, a few common and ordinarily innocuous salmonella bacteria claimed 25 lives; in all 107 out of 141 patients had suffered from the food poisoning.[51] The high incidence of death brought the epidemic to national attention, and hearings were held by the Subcommittee on Long-Term Care. The questions raised by this hearing were considered by the General Accounting Office at the request of Senator Moss. The second Senate hearing was held to receive this report from GAO and the intervening report of the State's own blue-ribbon panel of inquiry headed by Reverend Joseph A. Sellinger, President of Loyola College (Baltimore).

The Subcommittee learned: [52]

1. The GAO audit of Maryland revealed the same kind of duplicate payments under Medicare and Medicaid that were discovered in its audit in California. Duplicate payments are made possible when a claim turned down by Medicare is submitted to and paid by Medicaid, after which time Medicare reconsidered and paid all or part of the claim.
2. The GAO audit also indicated evidence in Maryland, as in California, where providers had collected Medicaid payments after the death of patients. In Maryland most of these cases were discovered and resulted when a patient died during a month—but the nursing home received payment for a whole month.
3. GAO discovered that Medicaid audits were not being conducted in Maryland. GAO indicated this was significant because Maryland has a "reasonable cost" reimbursement formula under Medicaid with a ceiling of $16.60 per month instead of the usual flat-fee Medicaid reimbursement formula. Under these circumstances, GAO concluded the audit is needed as a cost control.
4. GAO disclosed that, in the majority of cases, physicians did not view the bodies of those who died in nursing homes before signing death certificates. Senator Moss expressed his concern that a patient's death under these circumstances might have been caused by circumstances other than those recorded on the death certificate.

Other findings were reached by the Sellinger panel. In explanation of its report the panel said:

> The panel must state at the outset that it firmly believes that the specific failures evident in the current tragedy are *but symptomatic of the serious problems of all nursing homes in general.* (Emphasis added.) All the evidence suggests that the Gould Home was a better-than-average home. Thus, we feel that the recent events at the Gould Home

[50] Atlantic City Press, Jan. 2, 1971, p. A11.
[51] Hearings cited in Part 10, opening statement by Senator Moss.
[52] Report to the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging examining into certain Claimed Practices Related to Nursing Home Operations in the Baltimore, Maryland area. B–164031(3), by the Comptroller General of the U.S. General Accounting Office, p. 1–3.

could be repeated at virtually any nursing home in the State, unless the broader general problems are faced.[53]

1. The problem surrounding nursing homes is a problem for all American society today. The shamefully low priority our society places on the care and the comfort of its infirm is obvious throughout all the testimony and material we have received.

2. Licensing and inspection procedures, while superficially appearing thorough, are inadequate in Maryland, and are generally being "bureaucratic rituals" leading to a tidy series of papers filed as evidence of accomplishment rather than signals for action.

3. The medical procession, as a group, has not shouldered its proper responsibilities for the medical care and advice of patients in nursing homes.

4. The panel concluded that there is a fundamental contradiction between the goals of profitmaking nursing homes and the ideals of society. Nursing homes to make a profit must keep their beds occupied while the aim of our society must be to move the aged patients out of beds and into the community to lead as normal a life as possible.

C. Other Hearings

St. Petersburg, Florida.—The Florida hearing was triggered by a series of articles in the St. Petersburg Times by two young reporters who worked for several weeks in nursing homes in Pinellas County, Florida. Their charges of lack of medical care, unsanitary conditions and segregation of welfare patients who received less care and less desirable meals led to investigations by the Florida House of Representatives and Florida Senate. State Senator Louis de le Parte, who conducted the investigation for the Senate, and State Representative William Fleece, both testifing at the U.S. Senate hearing, attested to the accuracy of the indictment by the reporters.[54]

Hartford, Conn.—Hartford was picked as a site for a long-term care hearing because Connecticut, by consensus, has one of the best systems in the country. Of primary interest to the Committee was the "points system" instituted by Dr. Franklin Foote, Commissioner of the Connecticut Department of Health. Dr. Foote, explaining his system for the Subcommittee, said that Medicaid nursing homes do not receive a flat fee from the State to care for patients. All nursing homes are graded on the basis of such criteria as: How well do they conform to State regulations? How many nurses have they per patient? What is the aggregate in time and the quality of medical care received by patient? Nursing homes then receive reimbursement rates according to the total number of points they receive. Hypothetically, a Class A nursing home might receive $18 a day to care for a patient and a Class C nursing home would only receive $17 a day for this same patient. This sliding scale of benefits from Class A to Class E, provides a

[53] Other members of the Sellinger Panel were Dr. John H. Moxley III, Dean of the University of Maryland Medical School and Dr. David E. Rogers, Dean of Johns Hopkins University Medical School. The Sellinger Report is reprinted in Hearings Part 10, Appendix. This quote is found on p. 5 of that report.

[54] Hearings cited in footnote 15, Part 2, p. 173.

definite financial incentive to nursing homes to give good care and to avoid abuses or impropriety.[55]

San Francisco, California.—The central problem brought to the attention of the Committee was the fact that large numbers of the elderly poor in need of nursing home care are being placed in nursing homes 20, 40 and sometimes 100 miles outside the city. It was estimated that some 1,500 out of 5,500 Medicaid beneficiaries (called Medi-Cal in California) in San Francisco are living in nursing homes outside the city. This situation, supposedly brought about by high living costs and land values in San Francisco, has caused a shortage of nursing home beds in neighboring San Mateo County.[56]

A significant number of these displaced persons are Chinese. Some 19 percent of the residents of Chinatown are reported over 65, and only one nursing home in the city caters to the elderly Chinese. This home has a long waiting list and the nearest alternative nursing home is in Hayward, California.[57] Placing elderly Chinese in a conventional nursing home creates multiple crises for these patients. In addition to the trials of illness and old age, they cannot understand the language, are not accustomed to the food, and most would prefer to remain in old, dilapidated and crowded hotels where they can share their culture and the company of friends. Negroes and Spanish-speaking Americans in the area were also subject to forced emigration from the city.

Salt Lake City, Utah.—The Utah hearing was included because of controversy within the State caused by the charge of assault and battery leveled against an operator of a nursing home in Ogden, Utah. At the hearing, well known geriatrician Dr. Victor Kassel, testified that the present system of long-term care is not geared toward treating the whole individual; medical needs which may be attended by social and psychological needs are overlooked to the detriment of patients, their families, and ultimately the Nation.[58]

The Subcommittee on Long-Term Care is preparing a report based on its studies into "Trends in Long-Term Care" along with its recommendations to be submitted to the Congress in the fall of 1971.

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON NURSING HOMES

The 1961 White House Conference on Aging, recognized the growing importance of long-term care, calling for a broad spectrum of facilities, including home health services, together with comprehensive planning to avoid duplication and overbuilding. The Conference emphasized the need to improve the quality of care received by patients and to insure that no one is denied of needed service because of inability to pay. At the same time, it recommended appropriate controls in the hope that the Government would provide the highest quality of care for the lowest possible price. Meeting 10 years later, the 1971 White House Conference on Aging will be confronted by the tremendous growth

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[55] Hearings cited in footnote 15, Part 3, p. 267, 313 for more on the Foote "points" system.
[56] Hearings cited in footnote 15, Part 6, p. 490, 495, 503.
[57] Hearings cited in footnote 15, Part 6, p. 511–12.
[58] Hearings cited in footnote 15, Part 7, p. 612.

in the number of long-term care institutions brought about by the yearly infusion of more than $1.8 billion into the field by two Federal programs, Medicare and Medicaid. But only one senior in 20 is institutionalized; some because they have no other housing. Thousands more in the community are in need of nursing services, provided by institutions, but have no access to them financially. The White House Conference must take measure of Medicaid, Medicare and their inadequacies. At the same time, it should emphasize the positive and point the way to the model institution of the future. All these things it must do. But, in the final analysis, it must decide a difficult question which has never been faced in America: "What is our policy toward our infirm elderly?"

I. RECOMMENDATIONS IN 1961 AND THE RECORD SINCE

The recommendations of the 1961 Conference relating to long-term care are listed below with brief discussion of the progress that has been made toward reaching the stated goal.

1. THE NEED FOR A BROAD SPECTRUM OF INSTITUTIONAL NURSING FACILITIES.—Only by the end of 1970 has there been anything approaching a broad spectrum of *institutional* facilities. To be sure there has been a tremendous expansion in the number of nursing homes brought about, largely, by the enactment of Medicare and Medicaid; nursing home beds increased from 331,000 in 1961 to more than a million in 1970.[59] Most of these beds were either skilled nursing homes under the definition of Medicaid or extended care facilities under Medicare.

The interaction of the Social Security Amendments of 1967 and the Housing Act of 1969 provided the financing and the physical facilities making possible a third category of institutional care—intermediate care facilities completing a spectrum of care. The spectrum starts with the hospital offering acute care, going to the extended care facility, offering in the nursing home the extension of the kind of services granted in a hospital, skilled nursing homes, and finally, intermediate care facilities which offer personal care and minor medical attention. Unfortunately, not many nursing institutions offer much innovation and one facility very much resembles another from an organizational point of view. Few nursing homes offer adequate social services such as family counseling or psychiatric counseling and almost none offer preventive medicine.

2. THE NEED FOR COMPREHENSIVE PLANNING.—In the years following the 1961 Conference, Senator Frank E. Moss, the National Council of Senior Citizens, the American Association of Homes for the Aging and others have echoed the need for comprehensive planning to eliminate overbuilding in some areas and a scarcity in others.[60] In its field hearings the Subcommittee on Long-Term Care concluded the recommendation had not been complied with, except certain States such as

[59] Fact Book cited in footnote 4.

[60] Hearings cited in footnote 15, Part 2, p. 182–3. The lack of comprehensive planning was evident in Florida. St. Petersburg in Pinellas County had an occupancy rate of 69 percent being considerably overbuilt while some 20 miles away across Tampa Bay in Hillsborough County a shortage of beds was reported.

the State of Connecticut. In that State would-be providers are required to obtain a certificate of need from the State licensing agency before they can build a nursing home in any particular locality.

3. THE NEED FOR UNIFORM DEFINITIONS FOR LEVELS OF INSTITUTIONAL CARE.—Uniform definitions for the type of facility at the level of institutional care are far from a reality. Examples are provided by the State of Utah which presently has 10 different levels of care [61] and the State of Wisconsin which has 12 different levels.[62] Categories and definitions vary greatly from State to State.

4. THE NEED TO EXPAND INSTITUTIONAL FACILITIES SHOULD NOT DISCOURAGE NON-INSTITUTIONAL ALTERNATIVES, PARTICULARLY TREATING THE PATIENT IN HIS OWN HOME.—At the present time, Federal programs encourage treatment of patients in institutions. Recognition of this fact is represented by the language in the 1970 House-passed Social Security bill, H.R. 17550, discussed earlier in this chapter which would have provided a 25-percent bonus to the States if they elected to treat Medicaid patients through their Home Health Service rather than through their institutional facilities.

In terms of legislation, Home Health Services have been required under Medicare. These programs were functioning well and providing valuable services until 1970 when they were cutback by the same restrictive rules imposed retroactively on the Medicare nursing home benefits. Home Health Services were also required to be set up under Medicaid by June 30, 1970, but not all States have established such programs. This leaves only volunteer programs such as Meals on Wheels that bring services, medical or personal, into the home. It is noted that Senator Harrison Williams did introduce in 1970, S. 3333, which would have provided services of household aides under Medicare.[63] This bill is desirable as are plans for subsidizing families to care for the infirm elderly in their homes and senior citizen day care centers.

5. THE NEED TO INSURE THAT THE PATIENT IS IN THE RIGHT FACILITY AT THE RIGHT TIME.—In order to insure that the patient is in the right place at the right time, two programs were enacted into law—utilization review under Medicare and medical review under Medicaid.

Utilization review is aimed at the efficient use of facilities and preserving dollars (i.e., does the patient still need hospitalization or nursing care); medical review is concerned with the needs of individual patients. Utilization review has been functioning, with some success, under Medicare to the point where it was proposed that this program be incorporated into the Medicaid system (proposed in H.R. 17550). Medical review has different goals—calling for a committee of professionals, doctors, nurses and social workers, to undertake a patient-by-patient evaluation of the quality of medical care being received by them. Required by the 1967 Moss Amendments, medical review is not yet in force because only in February 1971 had HEW issued the necessary regulations telling the States how to set up this kind of program.

[61] Hearings cited in footnote 15. Part 7, p. 187.
[62] Speech by Senator Moss, Nov. 17, 1969, before American Association of Homes for the Aging, St. Louis, Missouri.
[63] Congressional Record, Jan. 24, 1970, p. S.499.

6. The Need for Nursing Institutions To Establish as Goals Individual Self-Reliance and Personal Dignity.—Because patients in nursing homes are both old and ill, it is conceeded that meeting this goal is a most difficult task. It is the conclusion of the Nader Task Force that the recommendation has not been met.[64] Notable exceptions might be the new emphasis on social, physical and occupational therapy, recreation and rehabilitation which were the hallmarks of the extended care program. Unfortunately these programs are too often regarded as ancillary and are the first to be cut when budgets get tight.

7. Needed Long-Term Institutional Care Should Not Be Denied Because of the Patient's Inability To Pay.—Unfortunately there is, and probably always will be, discrimination—blatant as well as invidious—which separates those who can pay for medical care from those who cannot. In field hearings, the Subcommittee on Long-Term Care discovered ample evidence that the poor welfare patients in nursing homes are segregated literally, and receive poorer quality of food and lesser attention from staff.[65] It is also true that those who do not receive adequate care and services, because they are poor, have their kin in those who pay exorbitant amounts for care they never receive. It has been the policy objective of Medicare and Medicaid to insure that adequate care is rendered—without regard to ability to pay. A lofty and highly desirable goal, but one still far from realization.

8. The Need To Improve the Quality of Care in Nursing Homes Through Licensing and Inspection Procedures.—The intent of the Kennedy amendment of 1967, in requiring the licensing of nursing home administrators, and the Moss amendments of the same year was to improve the quality of care received by patients. Before the Moss amendments, Medicaid did not even require a registered nurse in institutions functioning under the program. The enactment of the Medicare nursing home program also had a positive effect on the quality of care rendered in nursing homes. The Medicare program, in effect, created an elite type of nursing home—an extended care facility called by some mini-hospitals—and many nursing homes wished to belong to this elite to emphasize themselves as medical rather than custodial institutions. This is not to say that further improvement in the quality of care is not needed; preventive medicine techniques continue to be lacking within this context.[66]

9. The Need for the Federal Government To Insure That Sufficient Funds Are Available for Long-Term Care and To Establish Proper Safeguards for Efficient Use of Public Funds.—With $1.8 billion out of $2.5 billion received by the nursing home industry coming from the Federal Treasury, the Federal Government has a substantial interest in nursing institutions. The conclusion of most individuals within government is that sufficient Federal moneys are available. Indeed, the Nixon Administration, in 1970 suggested too much money was available and recommended that the Medicaid program be cut by $235 million; a suggestion which was accepted

[64] Recommendations, Nader Task Force Report; see also, footnote 32.
[65] Hearings cited in footnote 15, Part 2, p. 231, 235.
[66] Hearings cited in footnote 15, Part 7, p. 591.

by the House Ways and Means Committee and incorporated in H.R. 17550 as section 225(a). In 1971, the Administration again suggested cutting $444 million from this program.[67]

Nursing home providers view things differently, insisting that Medicaid rates in most States are inadequate to provide proper patient care and that private patients must help pay for public patients. Nursing home operators' complaints focus on State legislatures which are hard pressed to find enough funds for necessary State programs and often allocate low priority to patients in nursing homes or other institutions.

While there has been substantial progress in meeting the institutional needs of the 1 million institutionalized elderly, there continue to be serious problems. The needs of this group have been assigned low priority and the programs which have developed are often piecemeal, inappropriate, illusory and short-lived. What is reflected is a lack of a firm policy for the infirm elderly. At some point the elderly need to know what is the American policy; the rhetoric speaks of care and concern but the reality resembles confusion, high costs and, too often, poor care or no care at all for those who need it.

II. ISSUES IN 1971

The following recommendations are offered for the consideration of the 1971 White House Conference on Aging.

1. The Conference should endeavor to establish a policy with regard to treatment of the infirm elderly. This policy should consider the total needs of the individual including medical, dental, residential, social and psychological services.

2. States should be encouraged to require comprehensive planning for hospitals and nursing homes. No new health facility should be built except after a certification of need by the State Health Department.

3. That the Department of Health, Education, and Welfare, working together with the American Medical Association should develop programs with the goal of increasing physician participation in the care and activities of nursing homes. For example, physicians might be required to spend 6 months of their residency in a nursing home.

4. A Federal program should be established which would provide medical corpsmen discharged from the Armed Services with the necessary skill and training to function as medical assistants in nursing homes.

5. Federal matching funds should be available to help the States establish in-service training programs for nurses aides and orderlies.

6. The present State licensing and inspection system should be improved either by creating a cadre of Federal inspectors who would make unannounced inspections or by an HEW training program for State inspectors.

7. HEW should encourage States to adopt the "points system" such as functions in Connecticut for their Medicaid programs.

[67] Congressional Quarterly, Feb. 5, 1971, p. 290.

Instead of a flat rate, nursing homes would be compensated according to "grades" they receive from the State Health Department. These ratings or "grades" should be a matter of public record as a guideline for patients and their families.

8. To control overutilization of Medicaid facilities, States should rely upon programs of utilization review and medical review. Section 225(a) is an undesirable method of accomplishing this goal and this section of the present House Social Security bill, H.R. 1, should be deleted.

9. No single interest should be allowed to dominate the licensure boards required under the Kennedy amendment, which required the licensing of nursing home administrators.

10. Consumer groups should be established on the State level to monitor the care and performance of State nursing homes and to publish ratings of these institutions for the benefit of the public.

11. The waiver category, "in substantial compliance," which allowed the participation of many nursing homes in Medicare's ECF programs without meeting necessary requirements should be eliminated; nursing homes should be required to be in full compliance.

12. The Medicare nursing home program (ECF) should be redefined and revised to eliminate confusion and problems in administration. New regulations under the program should be announced only *prospectively* not retroactively.

CHAPTER V

NUTRITION AND OTHER CONSUMER ISSUES

Today's elderly must spend $7 out of every $10 of their income for housing, food, and transportation.

That estimate—made by the Bureau of Labor Statistics in a report [1] issued in 1970—described the situation as it applied to an "intermediate budget for a retired couple in an urban area during the spring 1969."

The B.L.S. estimates showed the following spending levels:

	Percent of income	Dollar amount
Housing	34	$1, 433
Food	27	1, 131
Transportation	10	412

The B.L.S. budget—which is not an "average" but is, instead, a statistical portrait of the income needed to provide a moderate level of living—amounted to $4,192 for all needs.

And yet, a 1968 Social Security Survey of the Aged had revealed earlier that *only about one-third of the aged units in that year had incomes large enough to provide at least a moderate level of living as defined by the B.L.S. budget for a retired couple.* And the budget total at that time was $3,930, or $132 less than the later budget figure.

The 15-percent Social Security increase voted in December may have narrowed the distance between the two B.L.S. budgets, but the 5.5-percent increase in the cost-of-living during 1970 has undoubtedly removed even that differential.

The inability of approximately two-thirds of retired couples to meet standards of an "intermediate" budget puts statistics about income of the elderly (see Chapter I) in another perspective: That seen by the elderly persons who, in today's marketplace, must often make hard choices between one necessity or the other.

Transportation and housing costs are discussed elsewhere in this report. For this chapter, special emphasis will be placed on nutrition, a subject which continued to receive searching scrutiny in 1970. In addition, the recurring question of "vulnerability" of the elderly to deception is discussed.

I. EMERGENCE OF NUTRITION AS A MAJOR ISSUE

Today, nutritional inadequacy is recognized as a priority problem among the elderly. At the forthcoming White House Conference on

[1] "Three Budgets for an Urban Retired Couple—Preliminary Spring 1969 Cost Estimates," B.L.S., January 1970.

Aging, nutrition will be one of the nine areas of need to be assessed by a Technical Committee established for this purpose. National, State and local organizations on aging have been invited to prepare recommendations to be forwarded to the Technical Committee on Nutrition, which will be included in the final deliberations of the Conference.

At a recent conference on nutrition,[2] Dr. Donald M. Watkin, the Chairman of the Technical Committee on Nutrition, White House Conference on Aging 1971,[3] stressed the need for the development of a national policy on nutrition and aging:

> A quantifiable policy on society's obligation to provide nutrition and health services (to the aging) must be defined. * * * Selection of (nutrition and health) choices for the aged of today is a matter of national emergency requiring action of such magnitude that it can be mounted only by a dedicated Federal Government using its powers to invoke equally concerted action by State, county and municipal authorities.

Dr. Watkin concluded his remarks with a challenge:

> While it would be unwise to prejudge the policies to be developed in 1971 (at the White House Conference on Aging), it is reasonable to refer back to the policies recommended by the White House Conference on Food, Nutrition and Health in 1969 and to note recommendations of the Panel on Aging that the Federal Government assume the obligation of providing the opportunity for optimum nutrition and health to every aged resident. Since the resources to achieve this objective are available, no policy falling short of this objective seems valid. The challenge lies in developing programs to implement policy and to encourage through education participation of the aging of all ages in this development process.

A. Progress Report on AoA Nutrition Programs [4]

The Administration on Aging Food and Nutrition program (established in 1968) demonstration and research projects were designed to test methods and delivery of nutrition services not to only improve the diets of the elderly participants, but also to enhance their feelings of self-esteem and self-reliance.

Title IV grants for this purpose were made to nonprofit public and private institutions, organizations and agencies serving the elderly across the Nation. Thus far, 10 projects have been completed, and 22 projects are still in operation in 17 States and the District of Columbia.

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[2] First Annual Joseph A. Despres Conference for Senior Citizens, Hudson Guild—Fulton Senior Center, "Why Meals for the Elderly—How?", New York City, Jan. 22, 1971. (See pp. 18–19, Watkin paper.)

[3] Dr. Watkin was also Chairman of the Panel on Aging, White House Conference on Food, Nutrition and Health. He is Research Associate, Mallory Institute of Pathology Foundation: Lecturer, Community Health and Social Medicine, Tufts University Medical School; and Acting Chief, Spinal Cord Injury Center, Veterans Administration Hospital, West Roxbury, Mass.

[4] Abstracted from, "Nutrition for Older Americans" by Jeanette Peclovits, nutritionist, Administration on Aging, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, in Journal of the American Dietetic Association, January 1971, p. 17.

The research component of the projects emphasizes an examination of the effect of loneliness on meal preparation and consumption by the elderly; the effect of social isolation on food habits; the impact of nutrition education; and the manner in which older people are influenced by their involvement in the programs—as volunteers or employees. The demonstration projects vary from community to community, serving a wide range of elderly participants from all races and ethnic groups, including the poor and middle-income elderly; those living in remote nonmetropolitan areas; and in central-city neighborhoods.

As the Title IV nutrition program progressed, the following five basic elements were gradually built into the projects:

—Outreach, to locate those isolated elderly in the community in need of such services;
—Meal service;
—Nutrition education as part of the program;
—Provision of a variety of related and ancillary services; and
—Establishing a mechanism for evaluation.

An evaluation, now underway, will determine the impact of the nutrition programs on the elderly participants, and explore the effectiveness of methods used in improving the dietary habits and well-being of older Americans. The ultimate goal of the evaluation project is to develop a model and guidelines for initiating, organizing, developing and operating local nutrition programs for the elderly.

In assessing the progress of the Title IV Nutrition program thus far, an Administration on Aging nutritionist had this to say:[5]

> The experience of AoA's nutrition program to date confirms the judgment that the problems of undernutrition and malnutrition cannot be solved independently of related problems of limited income and limited knowledge of nutrition; feelings of loneliness, rejection, and apathy; declining health, vigor and loss of mobility; physical handicaps that make food shopping and preparation difficult; and metabolic changes that accompany aging. No single approach can be fully responsive to the nutritional needs of the aging and no single system for the delivery of food and nutrition services is the total answer.
>
> The provision of meals in a group setting is a highly desirable approach to these interrelated problems because it fosters social interaction, facilitates the delivery of other services, and meets emotional needs of the aged while improving their nutrition. It offers an effective device for teaching by example the importance of a nutritionally adequate diet and what is essential to such a diet. It provides a framework for dealing with such everyday problems as transportation and housing arrangements which contribute to the nutrition problem.

The President's Task Force on Aging, in its remarks on nutrition, concurs with the AoA assessment:

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[5] Article cited in footnote 4, pp. 19–20.

> In examining the incidence of malnutrition among the elderly, the Task Force concluded that insufficient income was only one of several causes. The lonely older person who can afford an adequate diet but does not eat properly; the older person who finds going to the store too great a burden; the older person who is nutritionally ignorant; the chronically ill older person unable to prepare a hot meal—all are part of the problem. The Task Force believes that programs can be designed which, not only provide adequate nutrition to older persons, but equally important, combat their loneliness, channel them into the community, educate them about proper nutrition, and afford some of them an opportunity for paid community service.[6]

The Task Force made this recommendation:

> We, therefore, recommend that the President direct the Administration on Aging and the Department of Agriculture to develop a program of technical assistance and, when necessary, financial assistance, to local groups so that such groups can provide daily meals to ambulatory older persons in group settings and to shut-ins at home.[7]

Continuation of nutrition projects.—The Title IV nutrition research and demonstration projects are, by their very nature and purpose, temporary. Although the Administration on Aging has encouraged all project directors to seek out other sources of funding from their States, communities and municipalities, so that their nutrition programs can continue after the grants have been completed, such funding is hard to come by today, when most State and municipal budgets are going through financial difficulties.

Thus, there is increasing concern about what will happen to the thousands of older Americans benefiting from these nutrition projects once the Title IV funds run out.[8]

Indeed, so much concern was generated in New York City, where one-third of the elderly population live below the poverty level,[9] that a special conference was called this year to discuss ways of creating a funding mechanism that would allow for continuation of nutrition projects. The conference was conducted at the Hudson Guild—Fulton Senior Center, where one such nutrition project is still in operation. It was attended by representatives from Federal and State government, professionals in the field of nutrition and aging, many of the Title IV nutrition project directors from around the Nation, and by the elderly participants themselves.

The project director of a Title IV food and nutrition program at the Henry Street Settlement in New York City, which faces termination on March 30, 1971, urged that some means be found to continue the program because:

> If these programs have to close, *thousands of people will end up in nursing homes or homes for the aged at a higher cost to the taxpayer.* (Emphasis added.) Many older people

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[6] In "Toward a Brighter Future for the Elderly"—The report of the President's Task Force on the Aging, April 1970, p. 48.

[7] Report cited in footnote 6, pp. 49–50.

[8] See Developments in Aging, 1969, pp. 50–51, for example of a nutrition project that terminated.

[9] According to Alice Brophy, Executive Director, New York City, Office on Aging, who conducted a panel at the conference cited in footnote 2.

> will face the prospects of malnutrition . . . By far the largest group (of elderly participants) includes widows, widowers, with no one to cook for them, or single persons living in a furnished room or resident hotels where kitchen facilities are lacking.[10]

And, an elderly gentleman participating in the Conference discussion, appeared to sum up the feelings of other elderly participants in these nutrition programs when he said:

> Three years ago, the Federal Government gave us a bone (the nutrition projects). We have worked hard all our lives for the United States. Now we are entitled to some meat.

Mr. Jack Ossofsky, Deputy Director of the National Council on Aging, spoke at the Conference and called for: "A national operation of 'loaves and fishes' to assure that no older person in the country goes hungry." He suggests that: "The core of the program be community meal services in a socially positive setting; and that it include, wherever appropriate, home-delivered meals for those who are home-bound."

He continued, "The development of such a program would not only meet the nutritional needs of the elderly but the income and employment needs of many older persons by creating job opportunities for those (in the communities served) who can and want to work—in the preparation, service and delivery of meals. This will help establish community ties to the programs, to say nothing of keeping the community aware of their availability." Mr. Ossofsky concluded by urging: "We must pass legislation so that the Title IV Nutrition projects that will be terminated shortly can be saved, including funds for adequate research on the nutritional needs of the elderly. But we cannot wait for evaluation and research to implement such a program. We can see before our eyes the validity of these nutrition projects."

B. A Legislative Initiative

Legislation introduced in the House of Representatives during 1970 would meet the major demands in Mr. Ossofsky's proposal, and would also provide the "meat" which would allow the Title IV Nutrition projects to continue and grow in number of such programs.

On May 13, 1970, Congressman Claude Pepper introduced H.R. 17612, "Title VII of the Older Americans Act: Nutrition Program for the Elderly." The bill would authorize:

- —A new division within the Food and Nutrition Service of the Department of Agriculture for the administration of the Nutrition Program for the Elderly.
- —Making full use of existing services within the Department, including, but not limited to, the Federal Extension Service.
- —And consultation by the Department of Agriculture with the Administration on Aging, Department of Health, Education and Welfare in the planning and implementation of such a program.
- —Federal, State and local funding on a matching basis for these nutrition programs, including the utilization of surplus com-

[10] In letter to Committee on Aging from Mr. Edward Kramer, Project Director, Food and Nutrition Program at Henry Street Settlement, New York City, Jan. 11, 1971. Mr. Kramer reiterated his written remarks at the above mentioned Conference.

modities, for the preparation of at least one hot meal per day, 5 days a week, at a reasonably low cost to the participants.

—A categorical grant mechanism to carry out the "Nutrition Program for the Elderly", whereby the Federal Government would underwrite the cost of equipment, labor, management, supporting services and food (under a 90–10 matching).

—In order to be eligible for such grants, States must submit a plan that guarantees that any such nutrition project would provide at least one hot meal a day for elderly persons within their jurisdiction; this meal would contain a minimum of one-third of the recommended daily dietary allowance for an elderly person.

Some doubt as to the wisdom of placing the program under the jurisdiction of the Department of Agriculture was expressed before the Select Subcommittee on Education, House Committee on Education and Labor hearings. As stated by one witness:

> The Department of Agriculture has evidenced virtually no awareness of the particular needs of older people * * * The very acts of placing surplus commodity depots in locations most inaccessible to the relatively immobile, urban aged; of packaging such commodities in quantities unsuited to use by the single aged; of publishing food guides which few elderly can, or feel inclined to, read suggests some insensitivity to the needs of this major population group.[11]

And, while the Commissioner on Aging, John B. Martin, stressed the need for such nutrition programs for the elderly—noting that 92 percent of the elderly persons participating in the Title IV Nutrition projects have incomes of less than $3,000 a year, and 40 percent reported incomes of less than $1,000 a year [12]—and the desirability of a national program of nutrition services to the elderly; he also made clear the Administration's doubts about H.R. 17763:

> While we share the ultimate goals of this legislation, we do not believe that a categorical grant program focused on nutrition alone will really meet the needs of the elderly. The issue we should be considering is the proper approach for meeting the full array of needs of the elderly for social services, including nutrition services, and the ability of the Federal, State and local governments to meet those needs in an efficient and effective manner * * * We believe that the best approach that the Nation can take, to solve nutritional problems of older persons, is one which integrates nutrition services into a system of comprehensively delivered social services * * * Therefore, while we favor additional efforts to meet the nutritional needs of the elderly, we must oppose the enactment of H.R. 17763.

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[11] In testimony by Mrs. Sandra Howell, Project Director, Gerontological Society, before the Select Subcommittee on Education, House Committee on Education and Labor, Sept. 17, 1970, Washington, D.C. (p. 2 of her statement). Mrs. Howell was also the coauthor of "Nutrition and Aging: A Monograph for Practitioners" published by the *Gerontologist*, Autumn, 1969.

[12] In testimony by John B. Martin, Commissioner of Aging, at hearing cited in footnote 11.

The Commissioner introduced an alternative approach:

> As an alternative approach the Administration has developed a four part proposal which is directed toward the objectives of H.R. 17763; will meet them within sound fiscal and administrative requirements; and will result in the improved delivery of social services to older persons. This proposal consists of:
>
> 1. Introducing amendments to the proposed Title XX of the Social Security Act to permit financing this program from a large and flexible source;
> 2. Conducting a major test of the provision of nutrition services to the elderly, as an integral part of a more comprehensive social services network;
> 3. Increasing the availability of convenient places in which to deliver nutrition services to the elderly; and
> 4. Providing technical assistance to the States and communities to facilitate the development and local delivery of nutrition services for older persons.
>
> Shortly, the Administration will submit to the Senate an addition to the proposed services amendment to the Family Assistance Act (H.R. 16311), to include nutritional services for the elderly among those individual and family services for which Federal bloc grants will be made to the States.

Comprehensive as this approach may appear to be, it should be remembered that the Family Assistance Plan was not passed by either House of Congress, and it now faces the lengthy process of hearings and debate in the 92d Congress before it can be passed and signed into law. (In addition, no Administration amendments to implement the Commissioner's recommendation were introduced in 1970.) *Moreover, many of the Title IV Nutrition projects face termination within the next few months, cutting off desperately needed nutrition and social services to the thousands of older Americans now benefiting from these programs.*[13]

C. Food Stamps and the Elderly

There is no doubt that the Food Stamp program has served many thousands of elderly persons denied access to an adequate diet without such assistance. However, deficiencies in the program, documented in an earlier report,[14] may keep many more older persons from participating in the program. Those deficiencies include:

—Transportation problems in getting to and from sites where food stamps are sold.
—Long lines at Food Stamp sites are unbearable to many feeble elderly individuals.
—The nonassistance eligibility requirements[15] for participation

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[13] Congressman Pepper, in a wire directed to the Hudson Guild—Fulton Senior Center Conference (cited in footnote 2), stated that he plans to reintroduce the legislation in the 92d Congress.

[14] See Developments in Aging, 1969, pp. 51–53 for description of deficiencies in the Food Stamp Program.

[15] Under Section 5 of the Food Stamp Act of 1964, nonassistance households (those not on welfare) in which some or none of the members are on welfare, are only eligible "If the income from all sources and liquid resources do not exceed the approved standards for the State"—U.S. Department of Agriculture, Dec. 1, 1970.

> in the program is too stringent (averages from $1,500 to $2,000 allowed savings) for many who live on inadequate fixed incomes but who fear giving up their small savings, and therefore refuse to participate in the program.

In some States, certain counties are experimenting with issuing Food Stamps by mail, which is helpful to elderly recipients—especially those who live in rural areas. And, in West Virginia, a pilot program has enabled the entire States' Food Stamp program to operate through the mails.

The West Virginia experiment.—In this rural State, 20 percent of all Food Stamp recipients are elderly, representing almost 20,000 households.[16] Even though there are distribution sites for the stamps in each of the State's 55 counties, inaccessibility of the distribution sites has been described as one of the "chief deterrents to their more widespread use." [17] In 1969, the State Department of Welfare augmented the distribution sites with the cooperation of some 60 banks throughout the State—to also serve as purchasing points. However, all the stamp issuance points were commonly "clogged with lines * * * (which presented a) * * * hardship to those who found it necessary to use Food Stamps." [18] A survey conducted at one of the major Food Stamp offices brought many other problems to the attention of officials of the State Department of Welfare, including:

> The lack of transportation to get to the Food Stamp office; the physical inability to leave their homes at the necessary time to purchase the stamps; and the cost of transportation which took away * * * the advantages of * * * the stamps.[19]

Indeed, it was found that individuals paid from $3 to $10 for transportation in order to get to the Food Stamp office, which obviously negated the advantage of purchasing the stamps.

HOW THE PROGRAM WORKS

Under the new system, welfare recipients are permitted to have the cost of Food Stamps deducted from their welfare allotment. Food Stamps are included in the envelope with welfare checks that come through the mails. Those whose welfare assistance is too small to allow for such deduction, may mail a check or money order to the Food Stamp office, and receive the stamps back in the mail; or go to the issuance sites (which still operate) to pick up their checks. Those who are not welfare recipients (nonassistance households) may also take advantage of having their Food Stamps sent to them by mail.

Since pressure has been lifted from the Food Stamp sites by the fact that so many stamps are issued by mail, the lines at the sites are no longer as long.

After just 2 months of operation, 52 percent of the eligible elderly citizens of West Virginia were participating in the new mail delivery

[16] Abstracted from testimony of Edwin Flowers, Commissioner of Welfare, State of West Virginia, in hearings on "Older Americans in Rural Areas—Transportation" Part 11, Charleston, West Virginia, October 27, 1970, pp. 27–41 transcript.
[17] Cited in footnote 16, p. 31 transcript.
[18] Cited in footnote 16, p. 32 transcript.
[19] Cited in footnote 16, p. 34 transcript.

system. One reason for this response was the extensive publicity campaign, promoted in the news and television media, about the new program. In addition, 100 college students were designated the summer before the program began, to go into the hollows to seek out isolated rural elderly persons and tell them about the new program. Preliminary reports show that some 30 percent of the elderly persons contacted in this manner have begun to take advantage of the new mail delivery system.

This pilot program could well serve as a model for the Federal Government in the development of a stamp program that is more accessible to older Americans.

Changing from Commodities to Food Stamps.—More and more States, cities and localities throughout the Nation are changing over from the Commodities to the Food Stamp program.[20] In New York City, for example, commodities were distributed in a manner which made it difficult for many elderly persons to participate in the program. Indeed, in a city where 1.1 million persons are public assistance recipients, only 10,000 persons were enrolled in the Commodities program.[21]

However, in September of 1970, New York City joined with 63 other Social Service Districts in the State to change from Commodities to the Food Stamp program. Aside from the public assistance recipients, who are automatically eligible for Food Stamps, an estimated 775,000 adults and children among the working poor (nonassistance households) may also benefit from the new Food Stamp program.[22]

The New York City Department of Social Services operates 58 Senior Centers, with a membership of over 24,000 elderly persons—more than 20,000 of whom are not on welfare, but who will be eligible for the Food Stamp program. (For those older individuals who qualify for the program but who do not have cooking facilities, supplemental allowances are provided with their public assistance checks to cover the cost of meals taken in restaurants.

In an attempt to enroll as many elderly persons as possible in the new program, the City Department of Social Services is employing the elderly themselves—about 80 senior citizens will ultimately be hired on a part-time basis—to work on the program as clerks and dispatchers in the Food Stamp sites.

With banks and other check-cashing outlets cooperating with the Department of Social Services in the issuance of Food Stamps (as of September 1, over 630 banks and more than 230 check-cashing outlets had agreed to participate in the program), the Food Stamp program may bring desperately needed assistance to thousands of poor and near-poor elderly New Yorkers.

AMENDMENTS TO THE FOOD STAMP ACT

On January 11, 1971, the President signed into law the "Amendments to the Food Stamp Act of 1964" (H.R. 18582), which includes provisions that may benefit many older Americans, but also includes

[20] According to the Department of Agriculture, 45 States plus the District of Columbia, were enrolled in the Food Stamp program as of Dec. 31, 1970; and 1,986 Project Areas were participating in the program.

[21] See Developments in Aging, 1969, pp. 52–53, for description of deficiencies in Commodities program, especially in New York City.

[22] Abstracted from "Food Stamp Program Begun in New York City", *The Cameo*, New York State Office on Aging Newsletter, p. 6, November 1970.

those which may create deterrents to participation in the program for many current and potential elderly Food Stamp recipients.

Provisions which affect the elderly.—The new law will:

—Require no less than 50 cents per person per month or 30 percent of the household's income, as payment in order to participate in the Food Stamp program.

—Direct the Secretary of Agriculture in consultation with the Secretary of Health, Education and Welfare, to establish new uniform national standards of eligibility for participation in the program, including income limitations, and liquid or nonliquid asset limitations for those persons not on welfare (under the Food Stamp Act of 1964, States set their own standards).

—Expand the Food Stamp program to permit persons 60 years of age or older who are nonambulatory, homebound or feeble, to use Food Stamps to purchase meals delivered to them by nonprofit organizations or local government agencies. The preparing agencies or organizations cannot utilize federally donated foods (Commodity Food program) for this purpose, however.

—Permit the issuance of free Food Stamps to households or individuals with incomes below the poverty level. For example, a four-person household with an income of less than $30 a month will be eligible for free Food Stamps.

—Deny Food Stamps to an otherwise eligible household, between the ages of 18 and 65 (mothers with dependent children and students excepted), who fail to register for or accept employment at public work at not less than the applicable State or Federal minimum wage, or $1.30 an hour if there is no applicable minimum wage. There is a distinct possibility that a number of these provisions may have serious implications for the nutrition of the elderly. Indeed, the expansionary measure dealing with home-delivered meals may put restrictions on those community dining programs that also deliver a number of hot meals to the homebound (most of the Title IV Nutrition project include a home-delivered meals component), because they will still be able to utilize certain commodity foods for the meals served in a group setting, but will not be allowed to use those foods for the meals prepared for home delivery. About 4 percent of older Americans are homebound at any one time, and for these people, the home-delivery of meals can be a great benefit.

The earlier Senate-passed measure, S. 2547 [23], authorized elderly individuals to exchange Food Stamps for meals prepared and served, in either group settings or delivered to their homes, if they did not have cooking facilities, or reasonable access to such facilities; or if they were homebound, feeble or otherwise disabled.

In view of the recommendation of the President's Task Force on the Aging related to meals served in a group setting for the elderly; and the Administration's proposal which would implement such a program on a national scale, it would appear that allowing older Americans to exchange Food Stamps for such meal service is a necessary addition to the Food Stamp program—and one that is imperative to the health and well being of older Americans.

[23] See Developments in Aging 1969, pp. 53–54, for discussion of S. 2547.

In an attempt to determine the impact of the new law on the elderly, the Committee on Aging prepared a survey questionnaire which was mailed to all State Commissions on Aging throughout the Nation.

D. School Lunch Program: Massachusetts

Twenty-two municipalities in Massachusetts are now participating in a program which provides a noon meal in schools to low-income elderly over 59 years old. The conditions:

1. The charge to each person for each lunch shall not exceed 50 cents.
2. Lunches shall meet State nutritional standards, and procedures shall be approved by the Commonwealth Bureau on Aging and the Commonwealth Bureau of Nutrition.

Mr. John C. Stalker, Director of the Massachusetts Division of School Facilities and Related Services, has informed this Committee that 14 applications, now on file, cannot be processed because of lack of funds. At least 100 additional communities have expressed an interest in the program.

Begun on a pilot basis with 10 communities in 1967, the project now serves more than 1,600 meals daily.[24]

II. "VULNERABILITY" OF THE ELDERLY CONSUMER

American consumers are now perhaps more alert to possible pitfalls for unwary shoppers than they were at the beginning of the 1960's.

They have, within recent years, observed or participated in increasing skepticism about the protection afforded them by governmental action and by the quality and ethical standards of manufacturers and dealers.

Whatever the future of "consumerism", one fairly constant theme deals with the so-called "vulnerability" of the elderly to the unique problems which arise in a population group subject to loneliness, chronic and often painful illness, and the desperation which often accompanies limited income and great need.

One of the latest statements on this theme[25] was issued by the President's Task Force on Aging in a 1970 report:

> The many instances in which older persons are exploited illustrate the vulnerability of the elderly as consumers. Particularly vicious are attempts to sell older persons goods and services for which they have no need. Published documented reports of such exploitation include: land fraud, patent medicines, physical therapy devices, fraudulent insurance, and home remodeling.[26]

A. Examples of Abuses

Enforcement officers for Federal consumer protection agencies—in their annual report to this Committee (see appendix 1 for com-

[24] For text of 1970 legislation authorizing broadening of the program see appendix 5, item 2, p. 326.

[25] For earlier discussion see "Frauds and Deceptions Affecting the Elderly," a report by the Subcommittee on Frauds and Misrepresentations Affecting the Elderly, Senate Committee on Aging, Jan. 31, 1965, and chapters on consumer issues in "Developments in Aging," annual report of the Committee, for 1966, 1967, 1968, and 1969.

[26] Report cited in footnote 6, p. 43.

plete text) have again provided illustrations of successful, prosecutions and continuing problems.

For example:

POSTAL INSPECTORS

Mail fraud arrests by U.S. Postal Inspectors during 1970 totaled 1,163, resulting in 910 convictions. These figures represent the highest number of arrests and convictions in the history of the Mail Fraud Statute, which was enacted by Congress in 1872.

Some of the mail fraud schemes which affect the elderly include: medical frauds, investment swindles, business opportunities, solicitation of funds, land sale swindles, matrimonial schemes, and chain referrals.

The U.S. Chief Postal Inspector also gave two examples of effective prosecution:

> Three so-called "physicans" were sentenced in the District of Columbia in October 1970, for submitting false documents to obtain licenses to practice medicine in Washington, D.C. Although none of the three were physicians, they were granted licenses, opened offices and treated patients under the name of the Southwest Medical Center. They had a number of elderly patients and participated in the Medicare program.
>
> Postal inspectors investigated a typical "business opportunity" case recently which resulted in the indictment of four individuals for mail fraud. These promoters sold purchase agreements for vending equipment and supplies to some 1,000 persons who were promised they would earn up to $1,000 a month. Most investors never received the equipment, and those who did earned little from the shoddy machines which the firm had placed in unsatisfactory locations. During the past 3 years, this venture resulted in a loss to investors of over $3 million.

FOOD AND DRUG ADMINISTRATION

By the end of 1970, the Food and Drug Administration had started proceedings to halt the marketing of over 300 drug products which were found to lack evidence of effectiveness or to be unsafe—because their risks outweighted their beneficial qualities.

The FDA's Intensified Drug Inspection program, begun in 1970, produced hundreds of corrections in production and control practices in the manufacture of prescription drugs. The agency brought 19 court actions against firms that did not comply with the requirements of the Good Manufacturing Practice Regulations. Moreover, 24 manufacturers of prescription drugs went out of business because of inability to comply with the regulations.

There was a sharp increase in the number of drug and therapeutic device cases filed in the Federal courts in 1970. A jump from 190 in 1969 to 295.

Voluntary recalls of defective or mislabeled drugs and devices increased from 910 in 1969 to 1,427.

The FDA reports that, "A high proportion of drug recalls involved products used by elderly patients."

A "Study of Health Practices and Opinions" funded by the FDA will be published in final form shortly. The study was developed to explore the susceptibility of consumers to health fallacies and misrepresentations. The final report, according to the FDA, is expected to shed new light on the health practices of the American public in general, and of the elderly in particular.

B. Federal Efforts To Inform the Consumer

In limited but often highly effective ways, several agencies are employing new techniques to provide information to the elderly consumer. (For a discussion of information programs by the Administration on Aging, the Office of Economic Opportunity, the Department of Housing and Urban Development, and the President's Committee on Consumer Interests, see reports from those Federal units in Appendix 1.)

C. Legislation Enacted During 1970

Two measures signed into law on October 26, 1970, will benefit many elderly consumers.

The Fair Credit Reporting Act,[27] effective April 24, 1971, will enable consumers (upon proper request and indentification) to receive the nature and substance of all information about himself (except medical information) on file with a credit bureau. In addition, the act permits consumers to protect themselves against the dissemination of inaccurate or incomplete information bearing on their credit standing, insurability or employability.

Another measure which bans the issuance of unsolicited credit cards [28] will also aid elderly consumers. Under this law, no credit card may be issued except in direct response to a request or application. Moreover, the liability of a credit card holder is limited to $50 in the case of unauthorized use of such credit card.

A number of other measures were introduced in the 91st Congress which would have directly aided the elderly consumer as well as other age groups, including one that would have established an Office of Consumer Affairs in the Executive Office of the President and a Consumer Protection Agency within the Federal Government, to provide adequate protection and representation of American consumers.[29]

Another proposal would have expanded the jurisdiction of the Federal Trade Commission to permit that agency to issue temporary injunctions or restraining orders against any advertising or practice which is unfair or deceptive.[30]

Still another would have required manufacturers of products costing more than $5 who offer warranties or guarantees on their products to clearly and conspicuously disclose the contents of such warranties or guarantees, and also prohibited any disclaimer if the terms warranty or guaranty were used in connection with a sale.[31]

While the Fair Credit Reporting Act and the ban on unsolicited credit cards are indeed worthwhile laws, which will undoubtedly help

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[27] Title VI of Bank Records and Foreign Transactions Act, Public Law 91–508.
[28] Title V of Public Law 91–508 cited above.
[29] The Consumer Protection Agency Act, S. 4459 (did not pass House or Senate).
[30] The Consumer Protection Act, S. 3201 (an Administration proposal, which did not pass House or Senate).
[31] Consumer Products Warranty and Guaranty Act, S. 3074 (passed Senate, was not acted upon in the House).

many elderly consumers who might be discriminated against (because of age and income level) by credit bureaus, or who do need or want credit cards sent to them, it is clear that much more remains to be done.

Federal consumer protection must be made accessible and available to the elderly, whose vulnerability to misrepresentation and deception has been amply documented. We need strong legislation to assure such protection—especially for the elderly—who, according to Mrs. Virginia Knauer, Special Assistant to the President for Consumer Affairs:

> Are among those who can least afford the loss, are least likely to know the legal procedures for recovery, are most hesitant to involve themselves with lawyers and the law, and are least able to pay the cost of litigation even if they know the procedure.[32]

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON CONSUMER ISSUES

A decade ago the consumer issue had not attained the priority—and controversial—status it has today. Within the last 5 years, however, government businessmen, individual elderly consumers have increasingly spoken out on unique problems that face the elderly in today's complex and often bewildering marketplace. This growing recognition of the older person's problems as a purchaser on a fixed income in a dynamic economy can be a positive force if it leads to efforts which will benefit, not only the elderly, but other consumers. For example, the "Truth in Packaging" Act has only limited usefulness if the elderly, and perhaps younger people, find the print on the label too small to read. For example, designers of automobiles may find that all drivers of all ages will be grateful for vehicles that permit easier entry than is now the case. For example, more precise advertising for so called "cure" drugs would be of help not only to the aging sufferer from arthritis, but also for the mother concerned about her youngster's ailments.

I. RECOMMENDATIONS IN 1961

The major consumer issue before the 1961 White House Conference was not recognized as such at the time—it was the inability of the elderly to obtain health insurance at prices they could afford. That issue was regarded primarily as a medical or an economic problem. Aside from that, consumer problems were only glancingly mentioned in the report on that conference.

II. THE RECORD SINCE 1961

Elsewhere in this report—as well as in this chapter—the elderly have been portrayed as a group of Americans who must live with a disproportionate share of poverty, near-poverty, or, for those more fortunate, "getting along on less even though we're comfortable."

[32] In Report on 1970 Activities of the President's Committee on Consumer Interests Relating to the Aging, p. 1.

Planners of the White House Conference—while they have established "needs" study groups on transportation, nutrition, health and housing—have not established any mechanism for correlating consumer needs expressed in those areas and others.

One protest of this policy was expressed at the Third Annual Meeting of the Consumer Federation of America on August 29, 1970, when the following resolution was adopted:

> Consumer Federation of America expresses appreciation to Senator (Frank) Church and the Senate Subcommittee on the Consumer Interests of the Elderly in bringing to national attention the needs of this group of citizens.
>
> *CFA takes note of the failure of this Administration on Aging in planning for the 1971 White House Conference on Aging to provide opportunity for explicit recognition of the consumer interest of the elderly.*
>
> CFA urges the Administration on Aging to meet this deficiency by adding to the nine areas of need already designated for special study in preconference planning, a separate study on the needs of the elderly for consumer protection and education.

III. ISSUES IN 1971

The need for a pre-White House Conference Special Study on Consumer Issues Affecting Older Americans is acute and readily apparent. Special attention should be paid to nutritional needs and the limited success thus far in implementing recommendations made by the Panel on Aging of the White House Conference on Food, Nutrition, and Health of 1969.[33] The Administration on Aging should give some thought to convening—during this spring or summer—a multi-agency workshop on consumer problems, similar to that conducted on transportation in 1970.[34] Special efforts, however, should be made to assure adequate consumer representation at any such meeting. In addition, Conference Task Forces and Technical Review Committees should be encouraged to identify and discuss consumer issues related to their subject areas.

[33] The AoA, members of the original panel, representatives of industry, and Government officials met on Aug. 7 and 8, 1970, to discuss next steps in implementing the panel recommendations. A description of that meeting appears in Appendix 1, item 1, p. 193.

[34] See Chapter X of this report, and pp. V and VI of "Older Americans and Transportation: A Crisis in Mobility," Senate Report No. 91–1520.

CHAPTER VI

LEGAL SERVICES AND THE ELDERLY

Typically an older American has had little contact with government agencies during his preretirement years—except to pay taxes or to perform a military obligation. But with advancing age he may find himself involved in complicated and baffling encounters with Federal programs. His inability to understand intricate Social Security regulations may cost him dollars he can ill afford to lose. Food stamps may be available to help provide nutritious meals. But what good are they, if he is unaware of their existence?

Like other disadvantaged persons, the elderly poor—as well as the non-poor—need competent assistance in understanding the lawful means for making their needs known and having them met. Yet, many have been forced to shift for themselves when confronted with a legal problem—whether it involves litigation, attempting to understand the "technicalities" of Federal programs designed to serve them, or planning their personal affairs. Large numbers are now denied precious benefits to which they are legally entitled simply because they are unaware that injustice exists. Others accept injustice because the impersonal governmental apparatus appears too formidable to challenge.

I. HEARINGS ON ELDERLY'S LEGAL PROBLEMS

To hear firsthand about these problems besetting the aged, the Senate Committee on Aging held a hearing in conjunction with the American Bar Association annual meeting in August at St. Louis, Missouri.[1] This hearing represented a "first" for the Committee in a number of respects. It was the first time that a joint inquiry on the elderly's problems had been conducted with the A.B.A. And it represented the first overall congressional hearing devoted exclusively to the legal problems affecting older Americans.

A working paper, prepared by staff attorneys for the Legal Research and Services for the Elderly projects,[2] served as a springboard for discussion. At the hearing answers were sought for two basic questions: (1) What can be done? and (2) What more should be done? However, it also became abundantly clear that such a vast subject—affecting the jurisdiction of numerous local, State and Federal governmental agencies—would require further hearings and additional follow-up work.

A. What Can Be Done

Convincing evidence was provided during the hearing about the numerous ways older Americans can be assisted when competent

[1] "Legal Problems Affecting Older Americans," hearing before the Senate Special Committee on Aging, St. Louis, Mo., Aug. 11, 1970.

[2] Legal Research and Services for the Elderly, sponsored by the National Council of Senior Citizens, for the U.S. Office of Economic Opportunity. For more detailed discussion, see p. 272.

counsel is available. With the aid of legal advocates,[3] older Americans have been able to cut through the tangles of redtape engulfing some governmental programs. Government misunderstanding, indifference, or neglect has also been overcome with forceful and effective representation. And the legal rights of the aged have been protected with full and fair hearings before impartial decisionmakers. Among the examples:[4]

Blind Man Recovers $4,600 in Back Payments.—Many potential recipients of Federal benefits never receive needed assistance, since they are completely unaware of the existence of helpful programs.

Such was the case for a blind Massachusetts man, who was living on Social Security as his sole source of income.

With the help of a legal advocate, he was certified by the Massachusetts Commission on the Blind for assistance under the Aid for the Blind program. His advocate also successfully contended that the client should be entitled to back payments. Recently the elderly blind man received a check for $4,600 in overdue payments. Now, he is in a much better position to pay his rent and discharge his other financial obligations.

Retroactive Disability Benefits for Elderly Widow.—An elderly Georgia widow is back on the road to financial recovery because of successful litigation filed by Golden Age Legal Aid project attorneys.

In her previous attempt to be certified for Social Security disability benefits, the client's request had been denied by the Appeals Council in the Social Security Administration.

GALA lawyers were not only able to make the widow eligible for future disability benefits but also were successful in recovering retroactive payments for 21 months. These benefits resulted in several hundred dollars for the needy client and helped to pay some of her overdue bills.

Chance Meeting Helps Public Assistance Recipient.—Today two elderly women in Massachusetts are receiving additional old age assistance payments because of a chance meeting with a legal advocate from the Council of Elders project.

The legal advocate met the applicants at the Welfare Department shortly after their claims had been denied by their social worker.

Within 30 minutes the advocate was successful in having their requests approved. He also argued successfully that their monthly old age assistance payments should be increased from $85 to $114, because they were on special diets. Other urgently needed assistance was also obtained, including special allotments for clothing, a new bed, and a surplus food card.

Further conversation with the social worker revealed that the women might also be eligible for disability assistance.

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[3] For a more detailed discussion of lay advocates, see p. 83.

[4] Excerpted from working paper "Legal Problems Affecting Older Americans," prepared for Senate Special Committee on Aging by Legal Research and Services for the Elderly, National Council of Senior Citizens, Inc., pp. 51–53 of hearing cited in footnote 1.

At the request of the advocate, the clients' hospital forwarded copies of their medical records. Now both receive disability benefits, and their financial position has improved markedly.

B. Findings of LRSE

Additionally, LRSE projects have identified a number of other legal issues for the elderly person applying for Federal benefit programs. Some of these questions may be solved by legislation. Others may require regulatory changes by administrative bodies. But these vital problems can be solved or, at least, substantially improved.

INTERIM PAYMENTS

Frequently an applicant for Social Security must wait to collect his benefits because he is unable to provide positive proof of the date of his birth or his quarters of coverage.

Once an applicant is certified, he is entitled to retroactive benefits. But during the waiting period, he may be in urgent need of some form of income. Moreover, this may work an economic hardship on the potential beneficiary, since his family or household responsibilities will continue during this time. Many States now provide emergency assistance from the date of application to the time eligibility is determined for adult categorical recipients in dire need.

For these reasons, the Committee urges that legislation be enacted to provide for interim payments for Social Security beneficiaries when there is reasonable certainty that the applicant's claim will be approved, and the time lapse between application and approval is necessitated by the practical difficulties in obtaining evidence concerning the individual's age, quarters of covered employment, or amount of benefits. It is further recommended that the interim payment would be equal to the minimum monthly benefit under Social Security.

LAY ADVOCATES

In law, as in other professions, there is an increasing need for paraprofessionals. Typically a legal services attorney is confronted with a broad range of problems, including: Litigation, explaining a Federal program for the benefit of a welfare recipient, representing a client before an administrative body, informing individuals about programs which can help them, and many others.

For some such functions, lay advocates can be helpful in allowing a lawyer to devote a greater portion of his attention to more complicated and difficult problems. At the Council of Elders project in Roxbury, Massachusetts, lay advocates—under the supervision of attorneys—have performed many valuable services for elderly clients. For example, with the approval of State agencies, they have assisted elderly poor persons at administrative proceedings.

Morris Gouldings, Counsel for the Council of Elders, gave this description of the lay advocates:

> . . . Indeed, they do better than many lawyers would, not only because they are elderly and naturally owe and receive

the respect which is due them as such, but because they have that additional advantage of knowing at first hand the type of problem on which they are advocating. The life of the law is indeed more experience than logic, and our program has been providing it daily.[5]

Projects such as the Council of Elders provide clear and convincing evidence of the effectiveness of elderly lay advocates. It is strongly urged that additional OEO funding be available to support projects providing similar services.

C. What More Should Be Done

Valuable as this assistance can be, there is still an urgent need for further procedural safeguards in government benefit programs. The necessity for these additional protective measures becomes especially pressing for the elderly poor who typically will have only a superficial understanding of the procedures and substantive issues raised during an administrative proceeding.

PRIOR HEARINGS BEFORE BENEFITS MAY BE TERMINATED

In *Goldberg v. Kelley*, the Supreme Court recognized the severe injury and economic hardship suffered by adult categorical recipients when their benefits are wrongfully terminated. The Court also imposed a requirement of a hearing before a termination could be allowed.

Now HEW regulations grant all categorical recipients—requesting a hearing because of a termination or reduction in benefits—the right to continued benefits until a hearing is held.[6]

However, this same right to a hearing prior to termination of benefits is still not available for Social Security recipients. But when their benefits cease, they may suffer the same economic hardships as adult categorical recipients. Moreover, approximately one-fourth of all elderly married couples and about two-fifths of nonmarried aged individuals rely almost entirely upon Social Security for their support.

It is recommended that HEW regulations be modified to provide for prior hearings before Social Security benefits can be terminated or reduced. In the absence of such action, it is urged that legislation be enacted to provide this procedural safeguard.

THE RIGHT TO COUNSEL

Under existing law, adult categorical recipients and Social Security beneficiaries have the right to be represented at hearings by legal counsel or other designated representatives.[7] However, the law does not provide for the payment by a public agency of the legal fees incurred by a claimant for services in conjunction with the hearing or later judicial review of the administrative decision. At present, lawyers are limited to a maximum fee of 25 percent of their client's total past-due Social Security benefits recovered at a hearing or subsequent court appeal. The purpose of this provision is to protect the elderly litigant from having his award diluted by excessive attorney fees.

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[5] Hearing cited in footnote 1, p. 25.
[6] 45 C.F.R. § 205.10(a)(5).
[7] 45 C.F.R. § 205.10(a)(2)(iii). Social Security Act § 206(a); 20 C.F.R. § 401.971–73.

But as a result, many claimants find it difficult to obtain counsel in controversies where legal representation would be needed most—in difficult, complex or protracted cases. In cases where the amount in controversy is small, attorneys may be reluctant to provide legal representation because they are likely to be inadequately compensated for their services. Many elderly claimants also find it difficult to obtain counsel in suits where the likelihood of success is in doubt or where there is a strong possibility of a court appeal. Moreover, large numbers do not even request hearings simply because they never even receive legal opinions regarding their chances for success. Yet, these individuals deserve the same effective legal counsel as wealthier clients. In many cases, their Social Security or welfare benefits represent all or nearly all of their means of support.

Equally important as the right to a full and fair hearing, is the right to be represented by counsel—regardless of an individual's economic status. A denial, termination or reduction of Social Security or welfare benefits can represent a severe hardship for persons living on limited, fixed incomes. In such cases it is recommended that the Social Security or welfare offices provide written notice to the claimant informing him of the availability of legal aid and where such services can be obtained without cost.

II. CUTBACKS IN FUNDING FOR LEGAL SERVICES FOR THE ELDERLY

Legal Research and Services for the Elderly—sponsored by the National Council of Senior Citizens under an OEO grant—is the only project in the Nation which deals exclusively with the legal difficulties encountered by the aged. During 1970 the 12 LRSE projects continued their active role in housing, health care, probate reform, protective services, advocacy training, legal representation, and others.

A major objective of this program has been to identify legal issues affecting the elderly and to develop solutions for their problems. Project attorneys, for example, have assisted State legislatures in drafting proposals to help the elderly—such as measures for reduced bus fares, protection for Social Security beneficiaries who also receive old age assistance, and rent control ordinances. They have also prepared helpful brochures to explain Federal benefit programs in language that the untrained layman can understand. In addition, elderly lay advocates have been trained to represent aged clients in administrative proceedings. A long-range objective of the program has been to demonstrate how the Nation's elderly can better be served by OEO legal services programs and by attorneys in private practice.

Yet, OEO funding for LRSE was reduced in 1970. And the number of LRSE projects has been trimmed from 12 to 5, in spite of a pressing need for greater action to assure the elderly of competent representation.

Instead of reducing efforts on behalf of older Americans, OEO should be strengthening legal services. The effectiveness of the Legal Research and Services demonstration program for the elderly has been proved beyond doubt. The Committee strongly urges that funding for this program be expanded in 1971.

III. ANOTHER AREA OF INQUIRY: PROTECTIVE SERVICES

In recent years increased attention has focused on the need to reexamine and develop more realistic standards of protective care for the incompetent or marginally incompetent. Fundamental to the concept of protective services are several basic questions: (1) Who is to be served? (2) Is it the community that is to be protected from the client? (3) Is it the individual who is to be protected from himself? (4) Or is the person to be protected from aggressive and perhaps arbitrary action by society? And underlying these crucial questions is a further issue: At what point is it both ethical and appropriate to intervene in an individual's life pattern?

During the hearing on "Legal Problems Affecting Older Americans," several witnesses underscored the need to exercise caution in determining when it is time to substitute another's decisionmaking ability for an allegedly incapacitated person.

Quite clearly, the removal of this basic attribute of citizenship can have very serious repercussions for the individual who is deprived of the right to decide for himself or to manage his own property or personal affairs. Dean George Alexander [8] pointed out:

> . . . It seems more appropriate to view the question of how the law should intervene, not as a question of maximizing the benefits of the aging, but of minimizing to the extent possible the deprivation of the civil liberties by removing their right to control their property.
>
> * * * * *
>
> Many of the aged suffer merely from memory loss and lack of familiarity with legal process, without having lost their judgment concerning their personal goals. A provision which allows their entire ability to manage property to be deprived seems a gross over-reaction to the problem.[9]

Increased attention has been given to this problem by attorneys. For example, the Committee on Legal Problems of the Aging of the Family Law Section of the American Bar Association has devoted considerable study to provide a working framework to deal with this issue and other related questions. In its second annual report the committee recommended that:

> 1. The Family Law Section of the ABA have a liaison representative with the National Commission on Uniform State Laws to assure that all proposed uniform laws—especially those dealing with guardianship, commital and mental health—will take into consideration the legal problems of the aged.
>
> 2. In courses of family law, there should be a specific area of training for the student regarding the legal issues of the aging to assure competency in handling the property and personal rights of the elderly.
>
> 3. The Family Law Section should work with law schools in developing legislation related to protective services for older Americans.[10]

[8] George T. Alexander, Dean, Santa Clara law school, Santa Clara, Calif.
[9] Hearing cited in footnote 1, pp. 10–11.
[10] Hearing cited in footnote 1, p. 10.

Another important development in 1970 was the national conference on "The Evolution of Protective Services for Older People"—sponsored by the Administration on Aging—which was held in San Diego, California, in April and May. At the conference, U.S. Commissioner on Aging, John Martin, outlined four basic areas for providing protection: (1) The life and liberty of the marginally functioning, noninstitutionalized elderly; (2) the civil liberties of these aged persons; (3) the professionals working in the field to free them from the burdens of anxiety about their authority; and (4) the community from the danger posed by the incapacitated person.

In calling the surrogate function "the heart and soul of a protective service program",[11] the Commissioner also noted:

> Such surrogate services are now inadequate, if not virtually nonexistent, in most communities, and I believe this is the gap we are all trying to fill.
>
> I feel strongly that as we develop a more adequate system of preventive and supportive services—which currently are included in the prevailing definition of "protective services"—the need for surrogate services will be diminished. However, at present, the necessity for surrogate services is clear in numerous cases where the mental and physical capacity of the client is too limited to enable him to function satisfactorily in his own behalf.[12]

In addition, the Commissioner recommended the establishment of comprehensive protective service units, including where possible, lawyers, physicians and psychiatrists. This unit would be responsible for follow-up review of the client—as well as evaluating his status and revising his care plan. Moreover, the Commissioner proposed:

> (1) Developing a new career for retired persons who, with appropriate instruction, would assume the responsibilities of a conservatorship after a team of professionals has evaluated a client and determined that this need exists; and (2) emphasizing in law school curricula the problems of surrogates and other related problems for the aged.[13]

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON LEGAL PROBLEMS

Ten years ago the focus of the conferees was on protective services—as part of an overall social services approach—to meet the problems of an aging population. Little emphasis was then placed on legal services as a means for coping with the institutional difficulties confronting the elderly.

I. RECOMMENDATIONS IN 1961

Instead, the delegates urged increased cooperation on the part of social agencies, legal aid and bar association, and the medical profession to study ways to facilitate the provision of protective services.

[11] "The Evolution of Protective Services for Older People," a report of the National Conference on Protective Services for Older People, p. 11.
[12] Report cited in footnote 11, p. 11.
[13] Report cited in footnote 11, pp. 11–12.

Additionally, the conferees recommended that these professional services should be offered in such a way to sustain an older person's potential for independence. Moreover, it was recommended that guardianship laws and practices should be studied with a view to assuring legal protection as well as personal attention and care for the mentally incompetent individual.

II. THE RECORD SINCE 1961

A number of protective service demonstration programs—funded under the Older Americans Act—are now yielding new and important information. However, most experts agree that more research is needed, not only to define more precisely the needs of the aged but also to determine the appropriate components of a protective service system, its administrative structure, and its coordination with community service delivery systems.

In 1964 the Economic Opportunity Act set up a national legal services program to further the cause of justice among persons living in poverty by providing legal advice, representation and counseling. Now free legal services are available in 265 offices staffed by 2,200 lawyers. The Legal Research and Services for the Elderly program has been funded by OEO to focus on the legal problems of older Americans. Two years ago the American Bar Association established its first committee to deal exclusively with the legal issues of the elderly.

III. ISSUES IN 1971

But in far too many instances, the elderly have become bogged down in a legal morass of complex procedures which completely bewilder them. Too often their claims become trapped in a legal labyrinth. And too often large numbers suffer needless anxiety, deprivation and injustice simply because they are unaware of existing help.

To solve these problems, many unresolved issues must be dealt with fully and effectively:

—How can the elderly poor receive legal services commensurate with their proportion of the total poverty population?

—Is a special emphasis legal services program needed for the elderly not only in OEO, but also by other Federal units?

—How can more paraprofessionals be used to allow lawyers to concentrate on litigation?

—Would mobile services, including legal and other related services, be helpful in meeting the special needs of the homebound elderly?

—Can outreach services be effective in encouraging withdrawn persons to seek out legal help for their problems?

—What role can the private bar play in assuring the elderly client every "break" which the law permits?

—How can our law schools prepare young attorneys to have a more thorough understanding about some of the special legal problems affecting the older client?

—What kind of legislation is needed to improve guardianship laws and practices?

CHAPTER VII

UNEMPLOYMENT AMONG "OLDER WORKERS"

Traditionally this Committee has focused on the unemployment of persons 65 and over and those approaching "retirement age." But in many cases chronic unemployment problems for workers may begin 20 years or so before workers are eligible for Social Security. And these difficulties can have a severe impact on later retirement income. Various indices now suggest that the critical period in the work lives of adults occurs during their late forties or early fifties. Beginning about age 45, a number of clearly discernible trends become evident:

—Occupational mobility is seriously limited;
—Employers may be reluctant to hire older workers, even though the Age Discrimination law [1] prohibits such practices;
—Unemployment increases;
—Long-term joblessness rises sharply;
—Labor force participation declines; and
—Poverty increases.

I. 1970 EMPLOYMENT PICTURE: "GRIM"

Steadily mounting unemployment all across the Nation in 1970 affected practically all segments of the economy. From January to December the jobless rate jumped sharply from 3.9 to 6 percent—adding approximately 1.8 million workers to the unemployment rolls. In December nearly 5 million individuals had lost their jobs. And the unemployment rate reached its highest level in 9 years.

A. One Million Older Workers Unemployed

All age groups were affected by the wave of widespread joblessness, whether in the form of mass layoffs, shorter work weeks, smaller paychecks or just plain "slow business."

But older workers and their families were especially hard-pressed. By the year's end, more than 1 million had lost their jobs, 68 percent more than in January.

In many cases a lifetime of savings was wiped out or severely depleted. Large numbers discovered that they lost more than their jobs. Thousands also lost their pension coverage.

For those "lucky" enough to locate new work, it frequently meant a reduction in pay—a reduction with profound effects for them and their families at a time when prices were going up.

[1] For a more detailed discussion of the Age Discrimination in Employment Act, see p. 95 of this chapter.

Unlike many younger persons—especially teen agers—most of the unemployed middle-aged and older individuals were heads of families. Furthermore, the loss of a job at this age can have an especially serious impact, since the older worker's family responsibilities are probably growing at this point. At this time he is typically making payments on his home, car and household appliances. Or he may have added obligations, such as financing his children's college education.

B. Long-Term Joblessness

Once unemployed, regardless of the reasons, the mature worker runs the greatest risk of long-term joblessness.

From January to December, long-term unemployment (15 weeks or longer) for persons 45 and older increased by 85 percent, from 148,000 to 274,000.

At the end of the year, one out of every four unemployed mature workers—in contrast to one in six for younger individuals similarly situated—was out of work for 15 weeks or longer.

And their very long-term joblessness (27 weeks or longer) was even more serious, increasing more than 100 percent in the past 12 months. At the end of the year, 126,000 mature workers had been without work for more than 6 months, more than 38 percent of the total number.

C. The "Drop-Outs"

The longer these individuals remain without work, the more discouraged they become. Eventually many give up in despair and simply stop looking for jobs. Once this happens, they are no longer classified as "labor force participants." And they are no longer counted as "unemployed."

As a consequence, unemployment statistics for middle-aged and older persons usually represent only a small portion of the overall depressing picture. They do not, for example, reflect the labor force drop-outs, the "hidden" unemployed.

In December 1970 nearly 8.3 million males 45 and older had withdrawn from the work force. Twenty years ago this figure was 4.1 million. Another 20.8 million women in the same age category were also not in the labor force at the end of 1970, 5 million more than in 1950.

Assuming that just 30 percent of these men and 10 percent of these women (a conservative estimate) wanted and needed employment, this would mean that the "real" unemployment for persons 45 and older would exceed 5.6 million—approximately 600,000 more than the total statistical unemployment in the United States at the end of the year. Moreover, this would represent an unemployment rate in excess of 15 percent for mature workers.

If current labor force participation trends continue, one out of every six men in the 55 to 59 age category will no longer be in the work force by the time he reaches his 65th birthday. Ten years ago this ratio was only one in eight. And the one in six ratio is only for the short run. Unless major policy changes are instituted, this ratio will accelerate during the 1970's.

II. LEGISLATION ENACTED IN 1970

In terms of volume of legislation for older workers, few employment measures were enacted in 1970. However, two laws were passed which could help create a more favorable climate for the hiring of the elderly as well as provide a mechanism for dealing with some of their special problems.

A. "National Employ the Older Worker Week"

One of the most pressing needs for solving employment problems of older Americans is to educate the public as to their true capabilities. Unfortunately many employers still have false stereotypes about the desirability or feasibility of hiring older persons. Information and educational efforts would, however, be helpful in making prospective employers aware of their many attributes—such as their experience, stability and dependability.

With widespread bipartisan support, 18 members of the Senate Committee on Aging [2] sponsored S.J. Res. 74, which would authorize the President to designate the first full week in May as "National Employ the Older Worker Week." Since 1959 the American Legion has designated the first week in May as "Employ the Older Worker Week." During this period the Legion presents awards to employers demonstrating active leadership in employing the elderly. The effect of S.J. Res. 74 is to make this practice a national endeavor.

On September 23 the Senate adopted this resolution. In December the House approved the resolution in modified form, consistent with its policy for commemorating a specific week annually rather than on a continuing basis. On December 15 the Senate agreed to the House amendment to designate the first full week in May 1971 as "National Employ the Older Worker Week." And the resolution was signed into law (Public Law 91–593) on December 28 by the President.

B. Employment Security Amendments

Approved on August 10, the 1970 Employment Security Amendments (Public Law 91–373) constitute the most far reaching changes to the Federal-State unemployment compensation system since its establishment in 1935. Nearly 5 million additional jobs will be covered under the new law.

Extended Unemployment Insurance.—Particularly significant for middle-aged and older individuals is a new program for extended benefits during periods of high unemployment for workers who exhaust their basic entitlement to regular State unemployment insurance. Costs for the new program would be shared on a 50–50 basis by the Federal Government and States.

An "extended benefit period," beginning after December 31, 1971, would be triggered by either a national or State "on" indicator. However, a State legislature may make the program operative earlier on

[2] Sponsors of S.J. Res. 74 include Senators Randolph, Williams, Bible, Church, Fannin, Fong, Gurney, Hansen, Hartke, Kennedy, Miller, Mondale, Moss, Murphy, Muskie, Prouty, Yarborough, and Young of Ohio.

the basis of the State "on" indicator alone. In such cases, the Federal Government would share the added costs of the compensation paid in any such State for the period prior to January 1, 1972.

A national "on" indicator would exist when the seasonally adjusted rate of insured unemployment in the United States equaled or exceeded 4.5 percent in each of the three most recent calendar months. There would also be a State "on" indicator when the rate of insured unemployment for that State; (1) equalled or exceeded, during a moving 13-week period, 120 percent of the average rate for the corresponding 13-week period in the preceding 2 calendar years, and (2) such rate was at least 4 percent.

During a national or State extended benefit period, the State would be required to provide each eligible claimant with extended compensation—at the individual's regular weekly benefit amount—for a period equal to one-half of his period of entitlement to regular compensation. But this could not be more than 13 weeks with an overall limitation on regular and extended benefits of 39 weeks.

III. WHAT STEPS SHOULD BE TAKEN TO PROTECT THE OLDER WORKER?

Training and education in the United States is still directed essentially at younger persons, whether it is transitional, remedial or supplementary. But the need for supplementary adult education or retraining is greatest for older persons who need to keep abreast with the rapidly changing developments in our complex society.

During the economic slowdown in 1970, many mature workers found themselves without work because of circumstances beyond their control. Large scale reductions in the labor force, plant closedowns, cutbacks in construction and automation forced hundreds of thousands from the payrolls to the unemployment rolls. Others also encounter difficulty in finding jobs because:

—Technology has rendered their skills obsolete;
—Training is unavailable to move into gainful employment;
—They are seeking the jobs of a bygone era; or
—They live where there is no longer any employment.

A. Need for "Midcareer Services"

Despite the high percentage of long-term unemployment among middle-aged and older workers, they continue to be underrepresented in existing manpower programs.

Only a relatively small percentage of the Nation's training and retraining efforts have focused upon persons 45 and older. During 1970 they accounted for only 4 percent of all enrollees in manpower programs.

If the special emphasis youth programs—such as the Job Corps and Neighborhood Youth Corps—are excluded, their participation rate rises to 9.4 percent.

Enrollees in manpower programs, by age group, fiscal year 1970

[Amounts in thousands]

Program	First time enrollments				
		Under age 22		Age 45 and over	
	Total	Percent	Number	Percent	Number
Total, all programs	1,051.4	68	716.8	4	46.3
Manpower Development and Training Act:					
Institutional	130.0	37	48.1	9	11.7
OJT	91.0	35	31.9	11	10.0
Job opportunities in the business section	86.8	47	40.8	4	3.5
Concentrated employment program	110.1	41	45.1	8	8.8
Work incentive program	92.7	23	21.3	6	5.6
Operation Mainstream	12.5	4	5.0	51	6.4
New careers	3.6	21	0.8	7	0.3
Youth programs:					
Neighborhood Youth Corps:					
In-school	74.4	100	74.4	----	----
Out-of-school	46.2	98	45.3	----	----
Summer	361.5	100	361.5	----	----
Job Corps	42.6	100	42.6	----	----

Randolph-Williams-Kennedy Bill.—Recognizing the need for a defined, effective policy commitment for maximum utilization of persons 45 and older, Senators Jennings Randolph, Harrison Williams and Edward Kennedy introduced the Middle-Aged and Older Workers Employment Act in May. In testifying before the Subcommittee on Employment, Manpower and Poverty of the Senate Labor and Public Welfare Committee, Senator Randolph emphasized:

> Our middle-aged and older workers should not be left behind by the progress which they have helped to create. Enactment of this legislation can help them to live productive, satisfying lives through gainful employment. The benefits of such an undertaking are many:
> —For the individual, a job can provide self-respect and independence;
> —For his family, a regular paycheck can bring a higher standard of living; and
> —for the Nation, better equipped personnel to meet our manpower demands.[3]

Senator Kennedy added:

> The manner in which a society deals with the employment problems of middle-aged and older persons is just as much an indication of its compassion and effectiveness as the measures

[3] Hearings on "Manpower Development and Training Legislation, 1970," Subcommittee on Employment, Manpower, and Poverty, Senate Committee on Labor and Public Welfare, pp. 2782–83, May 21, 1970.

it takes to meet the needs of its youth. There is no reason to favor one group at the expense of the other, because we can respond to the needs of both. Older persons should be provided with a wide range of reasonable employment alternatives to consider, depending upon their needs, desires, and capabilities. Enactment of this legislation can provide significant progress in making this goal a reality.[4]

This measure was eventually adopted as an amendment to the Employment and Training Opportunities Act, S. 3867.[5] The overall bill—the product of 22 days of hearings over a 2-year period—was designed to deal with rising unemployment by providing new work opportunities through public service jobs and related manpower services.

Major Provisions and Congressional Actions.—On September 17 the Senate passed the Employment and Training Opportunities Act, including the Middle-Aged and Older Workers Employment Amendment, by a vote of 68 to 6.

House action on its manpower legislation—H.R. 19515, the Comprehensive Manpower Act—was delayed until November 17. However the House-passed bill failed to include the special emphasis programs for certain target groups—such as middle-aged and older workers, Indians, migrant farm workers, and persons with limited English-speaking ability—who have been underrepresented in manpower and training programs.

At the Conference Committee in early December, the Senate provisions for mature workers were kept largely intact. Among the major proposals for middle-aged and older workers:

—Establishment of a midcareer development services program in the Department of Labor to assist persons 45 and older to find employment by providing training, counseling and other needed services.

—Directs the Secretary of Labor to designate full-time personnel experienced in manpower problems of middle-aged and older workers to have responsibility for program leadership, development and coordination.

—Supportive services for occupational advancement for employed workers who may be in a "dead-end" job.

—Training for unemployed individuals to prepare them for needed jobs in the economy.

—Broad authority for the Secretary of Labor to conduct a wide range of research and demonstration projects to focus on the special problems of the mature worker.

—Authorizes the Comptroller General to undertake a study to help increase job opportunities for older persons in the executive branch in part-time employment and job redesign.

—Directs that a special section in the manpower report of the President be devoted to means of maximizing employment opportunities for persons 45 and over in Federally supported manpower programs.

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[4] Hearing cited in footnote 3, p. 2787.

[5] Popular name of the bill was later changed to "The Employment and Manpower Act" in Conference Committee in December.

On December 10 the Senate and House cleared the conference bill for the White House by votes of 68 to 13 and 177 to 159, respectively.

Executive Action.—But on December 16 the Employment and Manpower Act was vetoed. In his veto message, the President raised strong objections to the public service features in the Conference bill.

> The Conference bill provides that as much as 44 percent of the total funding in the bill go for dead-end jobs in the public sector. Moreover, there is no requirement that these public sector jobs be linked to training or the prospect of other employment opportunities. W.P.A.-type jobs are not the answer for the men and women who have them, for government which is less efficient as a result, or for the taxpayers who must foot the bill. Such a program represents a reversion to the remedies that were tried 35 years ago. Surely it is an inappropriate and inefficient response to the problems of the seventies.[6]

The President also was critical of the increase in the number of categorical programs:

> These narrow categorical programs would continue to hamstring the efforts of committees to adjust to change in their local needs.[7]

On December 21 the Senate voted 48 to 35 to override the veto, but failed by 8 votes to meet the necessary two-thirds requirement for passing the bill without the President's signature.

There has long been a need to establish a comprehensive national effort to meet the employment, training, counseling and supportive services requirements of middle-aged and older workers. At present, few, if any, of the existing programs are providing a truly effective, overall approach for their unique and growing problems.

Without specific statutory direction, the outlook for improvement is not encouraging. For these reasons, the Committee renews its recommendation that a Middle-Aged and Older Workers Employment Act be promptly enacted to provide a comprehensive and well balanced approach to assure that adequate resources for employment opportunities, training and supportive services are devoted to the pressing needs of mature workers.

B. More Effective Enforcement and Implementation of the Age Discrimination Law

Passage of the Age Discrimination in Employment Act in 1967 [8] brought new hope for older workers. Many believed that the new law could open the doors for new employment opportunities previously

[6] Senate Document 91-118, "Employment and Manpower Act of 1970—Veto Message," p. 2.

[7] Document cited in footnote 6, p. 2.

[8] The Age Discrimination in Employment Act was signed into law on December 15, 1967, and became effective on June 12, 1968. It protects individuals 40 to 64 years old from age discrimination in matters of hiring, discharge, compensation and other terms, conditions or privileges of employment. Coverage under the law includes; (1) employers of 25 or more persons in an industry affecting interstate commerce, (2) employment agencies serving such employers, and (3) labor organizations with 25 or more members in an industry affecting interstate commerce. If a complaint is filed, efforts must first be made to eliminate the alleged discriminatory practice through conciliation, conference and persuasion before legal proceedings are instituted. Only after such attempts have failed are the civil remedies and recovery procedures available for enforcement of the Act.

closed to mature job seekers. But during 1970, several lawmakers raised questions about the adequacy of the enforcement of the law. At the end of the year, only 15 court proceedings had been instituted under the Act, although the law had been in operation for nearly 2½ years. In addition, a study authorized under section 5 of the Act—relating to institutional and other arrangements giving rise to involuntary retirement—had still not been undertaken.

Williams-Prouty Amendment.—In June, Senators Harrison Williams and Winston Prouty led a bipartisan effort for increased funding for the age discrimination law. Appearing before the Senate Labor-HEW Appropriations Subcommittee, Senator Williams noted:

> For fiscal 1971, approximately $1.5 million of the funding for the Wage and Hour and Public Contracts Divisions will be allocated for enforcement of the ADEA.
>
> A prompt increase in staff, however, is urgently needed now to enforce the age discrimination law more adequately.
>
> Therefore, I urge that the funding for these divisions be increased by $1.5 million to be used for enforcement of the age discrimination law. This would raise the appropriations for these activities to $3 million, the amount of funding authorized under the Act.[9]

In addition, the Senators urged a $500,000 increase in funding for research programs conducted by the Manpower Administration to finance the study authorized under section 5 of the Act.

Fiscal 1971 Labor-HEW Appropriations.—In November the Senate passed the Labor-HEW Appropriations bill (H.R. 18515) without a dissenting vote, and approved the Williams-Prouty recommendations in modified form.

An additional $206,000 was provided for the Wage and Hour Division, increasing the House allowance from $27,953,000 to $28,159,000. This $206,000 raise in the Senate bill was to be used for more personnel to strengthen the enforcement of the age discrimination law.

Additionally, the Senate report expressed the clear intent of the Committee that the study authorized by section 5 should be undertaken with the funding provided for activities under the Manpower Administration.

> The Committee also expects that within the amounts recommended the Department will initiate a study of institutional and other arrangements giving rise to involuntary retirement as directed by section 5 of the Age Discrimination in Employment Act.[10]

In Conference Committee the increase in funding for age discrimination activities was pared to $50,000.[11]

Despite the age discrimination law, many middle-aged and older workers are finding themselves involuntarily retired because of subtle forms—and in some cases overt acts—of age bias. Increased funding is still urgently needed to provide added personnel to

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[9] Hearings on Departments of Labor and Health, Education, and Welfare, and Related Agencies Appropriations for Fiscal 1971, Senate Appropriations Committee, p. 38, June 16, 1970.

[10] Senate Report 91–1335 to accompany H.R. 18515, Departments of Labor, and Health, Education, and Welfare, and Related Agencies Appropriations Bill, [Fisca year] 1971, p. 8.

[11] House Report 91–1729 to accompany H.R. 18515, Departments of Labor, and Health, Education, and Welfare Appropriations, [Fiscal year] 1971, p. 6.

achieve full compliance with the provisions in the act. The Committee also urges that the study relating to institutional and other arrangements giving rise to involuntary retirement be undertaken expeditiously.

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON "OLDER WORKERS"

In 1961 an economic slowdown had created serious employment problems for middle-aged and older workers. One of the major issues raised at that Conference was: What action can be taken in the public and private sectors to permit our Nation to take advantage of the skills and experience of older workers? At that time, there was also an emerging concern over the trend toward earlier retirement. In the judgment of the conferees, outmoded employment practices and compulsory premature retirement were producing harmful effects for both the economy and the elderly jobseeker.

I. RECOMMENDATIONS IN 1961

During the Conference, agreement was widespread that employment was vitally important for the older individual—not only for self-support and independence but also for healthful living and self-respect. In proposing an action policy for the 1960's, the Conferees called upon joint action by labor, management and government. Among the major proposals: (1) Action by employers and unions to encourage the greatest flexibility in retirement practices; (2) special effort by the public employment service to secure more part-time employment opportunities for older workers; (3) job redesign to enable mature individuals to continue to be employed; (4) action by labor, management, and government agencies to improve personnel planning practices that minimize the extent of displacement of workers because of technological change; (5) development of information on current and future employment trends in local industries and occupations; (6) providing better training and retraining facilities and methods to allow older persons to compete successfully in the labor market; (7) emergency income and welfare services for the long-term unemployed; (8) providing more adequate counseling and placement services for older workers; and (9) legislation to outlaw age discrimination in employment.

II. THE RECORD SINCE 1961

Some progress, to be sure, has been made since the adoption of these recommendations in 1961. Recognizing that older workers were having difficulty staying in employment, the eligibility age for Social Security benefits for men was reduced to 62 shortly after the first White House Conference. A law has been enacted to prohibit discrimination in employment solely on account of age. Several States have passed similar legislation. The Manpower Development and Training Act was enacted to provide training and retraining for persons whose skills have been outdistanced by technology. "Job Banks" now exist

in a number of communities to match an applicant's skills with available openings in the work force. And a Department of Labor Mainstream program has been established to provide employment opportunities for mature individuals in community betterment activities.

III. ISSUES IN 1971

Yet, today more than 1 million persons 45 and older are unemployed. Even during periods of high employment, we can expect at least 600,000 mature workers to be without jobs during any given month. And much remains to be done to make one's year of birth irrevelant in the minds of employers and others. But, how can this laudable goal be translated into an effective action policy for this decade? Before this can happen, the 1971 delegates must come to grips with the real issues affecting the mature worker:

—What can be done to stem the alarming increase in the "dependency ratio" [12] of workers to nonworkers?
—What can our Nation do to assure that middle-aged and older persons will have an equal opportunity with others to engage in gainful employment?
—Can a large scale public service program be effective in reducing high unemployment among older persons?
—How can part-time employment opportunities be expanded?
—Would tax credits to industries hiring older workers be an effective means for meeting some of their employment problems?
—How can an effective early warning system be developed to protect mature workers from large scale unemployment because of a plant shutdown or other permanent reduction in a community's labor force?
—How can the Federal Government be a model employer for persons 45 and older?
—What are the best methods for training older individuals for productive employment?

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[12] Using the commonly accepted definition of working age population to be all those 20 to 64 years old, the "dependency ratio" in the United States has reflected the following trends:

In 1950, for every 100 persons of working age there were 72.6 persons below 20 or above 64. Today, that dependency ratio has climbed to approximately 93.2. The older part (65-plus) of that dependency ratio is approximately 18.2 today.

But with the present high proportion of workers now claiming Social Security benefits before age 65, the "Employment Aspects" working paper warned that the dependency ratio can increase alarmingly. If workers aged 60 and over continue to be eased out of the labor force, this dependency ratio could approach 110. And the dependency ratio for the older group would jump from 18.2 to 28.3.

CHAPTER VIII

SERVICE OPPORTUNITIES FOR OLDER AMERICANS

For many older Americans, service in their communities can be a most rewarding experience. For others, it can also mean a new career. And for their communities, it can provide an effective means of delivering badly needed public services.

Equally important, service programs for the elderly can be tailored for their special needs—such as to work for pay or as a volunteer, or to work part time or full time. Moreover, the elderly provide a ready reservoir of talent to help local governments meet the needs of their citizens.

As one Task Force member for this committee viewed the problem:

> No longer is there any justification for forcing older workers out of the work force, nor is there any justification for discouraging them from supplementing their income by part-time employment. Instead, business and government should be actively engaged in creating part-time employment opportunities for older persons as part of efficient production.[1]

His comments are worth serious consideration at the White House Conference and in all preceeding activities.

I. TOWARD A NATIONAL SERVICE PROGRAM

Several outstanding pilot programs—such as Green Thumb, Green Light, Senior AIDES, and the Senior Community Service program [2]—have provided abundant evidence of the soundness of the concept of community services by older Americans. Building upon the solid achievements of these Mainstream programs, the Older American Community Service Employment Act (S. 3604) was introduced with strong bipartisan support in 1970.[3] In developing a national service corps, the bill would provide new employment opportunities for low-income persons 55 and older in vitally needed services—such as anti-pollution programs, health maintenance centers, schools, libraries, economic development activities, conservation of natural resources and others. Additionally, S. 3604 [4] would have provided a basis for

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[1] Dr. James H. Schulz, associate professor of economics, University of New Hampshire, hearings on "Economics of Aging: Toward a Full Share in Abundance," Part 11—Concluding Hearing, May 6, 1970, p. 1918.

[2] For more detailed discussion of these programs, see pp. 107–108, ch. IX.

[3] Sponsors of the bill include Senators Kennedy, Williams, Bible, Church, Cranston, Eagleton, Fong, Hartke, Hughes, Miller, Mondale, Moss, Muskie, Pell, Randolph, Yarborough, and Young of Ohio.

[4] On February 2, 1971 an identical bill (S. 555) was introduced. Sponsors of the legislation include Senators Kennedy, Church, Williams, Bible, Burdick, Cranston, Eagleton, Fong, Hart, Harris, Hartke, Hughes, Miller, Mondale, Moss, Muskie, Pell, Randolph, and Stevenson.

converting the existing successful pilot projects into permanent, ongoing national programs. A 2-year funding authorization of $95 million would provide new service opportunities for approximately 37,000 older persons—more than seven times as many as provided under Mainstream in 1970.

Three days of hearings were held in 1970 by the Special Subcommittee on Aging of the Senate Labor and Public Welfare Committee in Fall River, Massachusetts and Washington, D.C. At these hearings witnesses were in virtually unanimous support of the bill.

Elderly Participants.—Older persons expressed their deep personal satisfaction and confidence which they gained from community service. One Senior AIDE, who found new meaning in retirement after obtaining work at a local marine museum, told the Subcommittee:

> . . . I knew when I got up in the morning it was going to be a repetition of the day before. It was not very pleasant to know it was the same thing all over again.
>
> But since being down to the museum that all has changed. I know when I get up in the morning I have some place to go to.[5]

An 88-year-old man said that he got rid of his two boys when he joined the Green Thumb program:

> Those two boys left me, and the name of the first one was Arthur and the second one was Ritus. You put them together, and it meant arthritis was in my arms.
>
> At my age, I believe that Green Thumb is the reason I am living today. If it hadn't been for Green Thumb, I believe I would have faded away.[6]

Agencies Served.—Representatives of agencies assisted welcome the vital services performed by the senior "aides" and asked for more. A supervisor at a day nursery in New Bedford, Massachusetts, had this to say:

> Not only are they dependable, but they give of themselves in service. The job is a rewarding experience; not just a duty. And the reward is reciprocal. . . .
>
> It seems as though the young, or the activity of a new endeavor, has a certain effect on the older adult. They seem to have gained a sense of confidence, satisfaction, and security from their jobs; but what is important—they have discovered that they have talents that are marketable, and what is yet more important they, the senior aides, are vitally needed.[7]

The Experts.—And leading experts in the field estimated that millions of persons 55 and older would be willing and able to serve in their communities. When asked by Senator Kennedy how many older persons would be interested in providing part-time service in their communities, Dr. Blue Carstenson said:

> But if we really did a job, there could perhaps *be maybe 4 million or even 4½ million that would do it on a part-*

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[5] Testimony by Mr. John O'Keefe, Fall River, Massachusetts, "Older American Community Service Employment Act" hearings, Special Subcommittee on Aging, Senate Committee on Labor and Public Welfare, Fall River, Massachusetts, p. 18, April 4, 1970.

[6] Testimony by Mr. Reddrick Strickland, Newport News, Virginia, at hearing cited in footnote 5, Washington, D.C., p. 173, June 15, 1970.

[7] Testimony by Mrs. Eleanor Morton, Supervisor, West End Day Nursery of New Bedford, Inc., New Bedford, Massachusetts, hearing cited in footnote 5, p. 31.

time basis because of need and would meet the poverty guidelines." * * * [8] (Emphasis added.)

For most elderly participants, community service is more than just a job or a means of providing badly needed income. It can also mean a most satisfying experience serving people in their localities; a place for association; and a means to engage in purposeful activity.

For many older people, inactivity is the greatest enemy. But employment can overcome this problem.

The enthusiastic acceptance of existing community service pilot programs strongly suggests that there are many low-income older persons in virtually every community who are ready, willing and able to perform services. Greater utilization of their skills, experience and wisdom would benefit not only the elderly job seeker but the public as well. The Committee recommends early enactment of legislation—similar to the Older American Community Service Employment Act—to establish a national service program for older Americans.

II. OPPORTUNITIES FOR DAY CARE

A critical shortage of day care facilities now exists for working women with children. Today there are more than 11.6 million working mothers. Of this total more than 4 million have children under 6. But there are only about 13,600 licensed day care centers. According to Department of Labor statistics, these centers accommodate approximately 518,000 children.[9]

Various trends strongly indicate that the demand for day care centers will continue to grow quite rapidly during the 1970's. In the past 30 years there has been a dramatic increase in the number of working mothers, from 10 percent in 1940 to about 38 percent today. And these figures are projected to increase by 30 percent by 1985. Moreover, there is now greater acceptance in society of the movement of women out of the home into the work force. Another factor is the change in family living patterns, which formerly tended to be centrally located in one community but now are likely to be spread throughout the country. This has also caused an increased demand for day care—not only for the working mother but also during times of illness or family crisis.

Further impetus was provided for meeting the growing demand for day care facilities at the 1970 White House Conference on Children. One such proposal called for adequate Government funding to provide training for at least 50,000 additional child care workers per year for the next 10 years. In underscoring the need for positive action, Harvard child psychologist Jerome Kagan, the panel chairman, said that child care may prove to be essential for the survival of the family as "the central social unit in Western society." [10]

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[8] Dr. Blue Carstenson, director of rural manpower, senior member, and Green Thumb programs of the National Farmers Union. P. 160, hearing cited in footnote 6, Washington, D.C., June 15, 1970.

[9] Material excerpted from "Day Care: Demand Outrunning Growth," by Nancy Hicks, *New York Times*, Nov. 30, 1970, p. 1.

[10] "Parley Urges Day Care Plan for Children," by Morton Mintz, *The Washington Post*, Dec. 15, 1970, p. A2.

Older Americans may provide a valuable source of manpower for operation of day care centers. Several programs—such as Foster Grandparents[11] have already amply demonstrated the natural empathy between the elderly and younger children. In acting on day care legislation during the 92d Congress, it is recommended that consideration be given to: (1) establishing a policy to encourage employment of older persons in day care centers or (2) authorizing training of such persons for day care aides.

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON SERVICE OPPORTUNITIES

One of the key directives for the delegates at the 1961 Conference was to formulate legislative recommendations "for immediate action in improving and developing programs to permit the country to take advantage of the experience and skills of the older persons in our population."[12] And one of the major issues considered at that Conference was: How can this Nation more effectively utilize the wealth of talent with which older Americans are so richly endowed?

I. RECOMMENDATIONS IN 1961

Out of that Conference came emphatic recommendations for promoting part-time as well as full-time jobs for older workers. Additionally, the Conferees urged that the public employment services make special efforts to secure more part-time employment for elderly persons.

To foster more activities in behalf of the aging on a local and voluntary basis, the delegates recommended that the Federal Government support demonstration action projects proposed by private or governmental organizations to stimulate and initiate community services.

II. THE RECORD SINCE 1961

In his historic message on aging in 1963, President John F. Kennedy emphasized:

> The heart of our program for the elderly must be opportunity for and actual service to our older citizens in their home communities. The loneliness or apathy which exists among many of our aged is heightened by the wall of inertia which often exists between them and their community.[13]

In that same message, President Kennedy also urged the establishment of a National Service Corps "to provide opportunities for services for those aged persons who can assume active roles in community volunteer efforts."[14] Six years later a Retired Senior Volunteer

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[11] For a more detailed discussion of the Foster Grandparent program, see p. 133, ch. XI.
[12] Public Law 85–908. "White House Conference on Aging Act." Sept. 2. 1958.
[13] "A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens", Senate Special Committee on Aging Print, June 1963. p. 14.
[14] Print cited in footnote 13, pp. 39–40.

Program (RSVP) [15]—to recruit persons 60 and over to provide needed services in their localities—was established under the Older Americans Act.

In 1964 this Committee issued a report on "Increasing Employment Opportunities for the Elderly." Stressing the need for part-time, paid employment, the report recommended legislation to authorize Federal grants for demonstration projects to stimulate job opportunities for older Americans. Today there are a number of successful prototypes. A Foster Grandparent program allows low-income elderly persons to help disadvantaged young children. Several pilot projects under Mainstream [16] have convincingly demonstrated the effectiveness of aged persons in serving their localities.

And in 1970 the President's Task Force on the Aging also urged that more opportunities should be provided for the elderly to serve in their communities. To help provide this direction, the Task Force recommended that the President issue an Executive Order directing all Federal agencies to cooperate with the Administration on Aging in designing opportunities for older persons to render services in their localities. It was further recommended that the Older Americans Act be amended to authorize AoA to contract with appropriate Federal agencies for the rendering of services by elderly individuals in local programs which those agencies support.

> The need for expanded and varied opportunities to utilize the skills, talent, experience, and time of older persons as proposed in Recommendation 20, is apparent to the Task Force, not only because using their skills, talent, experience, and time has a special meaning for the elderly but also because these qualities enhance society.[17]

III. ISSUES IN 1971

But today the issue is *not* whether the aged can be attracted to service programs. Several projects have already shown that elderly persons derive a sense of deep personal satisfaction in helping others by helping themselves. Yet in our work-oriented society, these older participants are the exception rather than the rule. Existing community service programs now employ only a few thousand persons 55 and older. The main issue now is: What is the most effective mechanism for expanding opportunities for community service employment for the elderly? With this in mind, other questions must also be considered:

—What should the Federal Government's role be in helping to establish service programs?
—Should administrative responsibility for these programs be placed in the Labor Department, OEO, or other Federal agencies?
—What role would State and local government or private nonprofit organizations have?
—Should service programs be limited to the poor, or should the near poor also be eligible for participation?
—What new frontiers are there for expanding community service employment?

[15] For a more detailed discussion of the Retired Senior Volunteer program, see p. 133, ch. XI.
[16] For a more detailed discussion of the programs under Mainstream, see p. 106, ch. IX.
[17] "Toward a Brighter Future for the Elderly", the Report of the President's Task Force on the Aging, April 1970, p. 44.

CHAPTER IX

OEO PROGRAMS FOR THE ELDERLY

From the very beginning of the War on Poverty, in 1964, the elderly poor were identified as one of the target groups of the poverty program. Older Americans, however, have been underrepresented in OEO programs, since it was believed that the most critical problems affected the Nation's youth—especially among the children and young people of disadvantaged minority groups.

In recent years funding for programs for the aged poor has increased slightly. Yet, appropriations for OEO projects serving the elderly represented only about 6 percent of the 1970 budget outlay, although persons 65-and-over constitute about 20 percent of the total poverty population.

I. "SOS": SENIOR OPPORTUNITIES AND SERVICES [1]

During fiscal year 1970, $6.8 million was allocated for SOS programs. More than 700,000 of the elderly poor were served by the 208 projects in a wide variety of ways, including (1) training to prepare older individuals for part- or full-time jobs; (2) screening applicants for subsidized housing units; (3) home health services for the frail; (4) transportation for the infirm; (5) meals on wheels for the homebound; (6) consumer education programs to assist aged persons in buying food and budgeting their money; and (7) employment opportunities in these programs.

Another significant development in 1970 was the evaluation of SOS projects by Kirschner Associates, Inc. Particularly noteworthy was the finding that SOS is an effective means for identifying and meeting the needs of the elderly poor.

Among the major other findings:

—SOS programs have a low unit cost per beneficiary.
—Older Americans participate more actively in special programs designed for their own needs.
—Service opportunities in these projects have produced significant improvements in the aged's sense of dignity, as well as their physical and emotional well-being.
—SOS projects are enthusiastically accepted by local governments and attract a more generous measure of community support than other types of programs.
—These projects have provided badly needed outreach and referral services for the major national local welfare programs.

The Chewelah Experience.—Another important development was an SOS grant in June to Chewelah, Washington. In this one-industry

[1] For further discussion of history of SOS, see "Developments in Aging, 1969," p. 132.

town, the local brick factory notified its 125 employees that the plant would be closed. Many of the workers affected were 55 and over, and their outlook for obtaining jobs was dim. Two national experts on industrial displacement were sent to help plan a course of action.

An SOS grant was then made to the local community action agency to staff and carry out the mobilization effort recommended by the experts. Communitywide meetings and workshops generated much local support in locating employment for the displaced older workers. An added dividend was the upsurge in economic development in the locality. A garment industry moved into the town, creating many new jobs. An industrial park is also being developed, which may attract additional employers. Quite clearly Chewelah is improving economically.

1971 Outlook.—For this fiscal year, OEO plans to spend $7.8 million for SOS projects. In addition, funding will be available for the first time to cover the costs of training and technical assistance services in these program areas.

Recent findings by Kirschner Associates provide clear and convincing evidence of the effectiveness of senior opportunities and services projects. The Committee strongly urges that full funding be provided for SOS programs during the next fiscal year.

II. OPERATION MAINSTREAM

Operation Mainstream [2] is an employment program directed at the special needs of the chronically unemployed poor who have limited prospects for jobs because of age or other disadvantages. During 1970 five national contracts—sponsored by the National Farmers Union; National Council of Senior Citizens; National Council on the Aging; National Retired Teachers Association-American Association of Retired Persons; and Virginia State College—were extended to provide employment opportunities for approximately 4,900 low-income persons 55 and older. Moreover, a new project was funded in Roanoke Valley, Virginia.

In July, Kirschner Associates also began an evaluation of programs funded under Mainstream. The first phase dealt with the Green Thumb and Green Light programs, sponsored by the National Farmers Union. A preliminary report on these projects was completed in December. Phase two is expected to be completed during the spring of 1971 and will cover programs sponsored by the National Council of Senior Citizens, National Council on the Aging, National Retired Teachers Association-American Association of Retired Persons, and Virginia State College. Evaluation under phase three will apply to other Mainstream programs administered by the regional offices in the Department of Labor. Tenative plans call for completion of this study during the summer of 1971.

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[2] To be eligible for participation in Mainstream programs, an individual must be at least 22 years old and come from a family whose income is below the poverty level. Priority is given to persons who (1) have been unemployed for 15 weeks or longer, repeatedly unemployed during the past 2 years, or employed less than 20 hours per week for more than 26 consecutive weeks; (2) have completed some training but still remain unemployed; or (3) lack current prospects for training or employment because of age or other reasons.

Older person employment programs under Mainstream[3]

Sponsor	Enrollees	Funding
National Council of Senior Citizens	1,148	$3,446,912
National Council on the Aging	572	1,350,000
National Retired Teachers Association-American Association of Retired Persons	353	739,011
National Farmers Union	2,680	6,960,160
Virginia State	125	160,947
Total Action Against Poverty in Roanoke Valley	70	300,000

A. Total Action Against Poverty in Roanoke Valley

Initiated last July, Total Action Against Poverty in Roanoke Valley is a joint project carried out with assistance from the Department of Labor and the Forest Service of the Department of Agriculture. Funding is provided from the Labor Department, and the Forest Service furnishes supplies, equipment and vehicles.

This program represents a pilot effort in interagency cooperation to couple good employment practices with conservation, education and recreation. Participants range in age from 22 to 74, with the stipulation that at least 40 percent must be 55 and older.

The program employs low-income persons at the George Washington National Forest in eight counties in Virginia. Most of the work requires the development of trade skills, such as masonry, painting and carpentry talents. Additional training opportunities include recreational aides, park maintenance foremen, forest aides and clerical positions.

The goals of the project are to establish a large campsite ground in Hidden Valley and to improve existing facilities at Blowing Springs.

B. Green Thumb and Green Light[4]

During 1970 more than 2,400 Green Thumbers helped to beautify rural areas by planting trees and shrubbery; cleaning out lakes; restoring historical sites; and building picnic places and campgrounds. With the renewal of its contract in August, the program expanded to 17 States, adding Texas and Montana. Other States include Arkansas, Indiana, Kentucky, Minnesota, Nebraska, New York, New Jersey, North Dakota, Oklahoma, Oregon, Pennsylvania, South Dakota, Utah, Virginia, and Wisconsin.

Green Light, which is the women's counterpart to the Green Thumb program, began its second year of operation in 1970. Approximately 275 older women from 11 States participated as aides in libraries, schools, nutrition programs, day care centers, and elsewhere. One important change in the program was the greater emphasis placed on outreach and service activities.

[3] From report of Department of Labor to Senate Special Committee on Aging. For more detailed information, see app. 1, p. 234.

[4] Green Thumb and Green Light are sponsored by the National Farmers Union. To qualify for these programs, individuals must (1) be at least 55 years old, (2) be below the poverty income level, and (3) have a farming or rural background.

Particularly significant for both projects was the evaluation made by Kirschner Associates. Tentative findings reveal that the programs are effective and useful in providing purposeful job opportunities for low-income men and women with a farming or rural background.

Among the other important findings:

—The work performed by the Green Thumbers and Green Lighters has been of high quality.
—Participants have been overwhelmingly enthusiastic about their jobs.
—Green Thumbers especially like working outdoors and with others in a team effort.
—The programs have more than doubled the incomes of the participants.
—Many workers report that their work has helped to improve their health as well as their outlook on life.

C. Senior AIDES [5]

Operating in 20 cities in 1970, the Senior AIDES program provided employment opportunities for 1,150 individuals in a wide range of community service activities, including homemaker and health; medical support; food and nutrition; institutional care; home repair; child care; environmental; outreach; and social service administration. Administration costs were again kept at a minimum—an average of 15 percent of the overall investment, which is substantially less than most other programs. Average wages for the participants also increased from the 1969 level of $2.00 per hour to $2.17.

Once again, there was a high demand to participate in the program—with more than seven applicants for each position available. And requests to participate in the program have been received from more than 100 communities.

Recent studies by the National Council of Senior Citizens have also shown that working in their localities tend to make the Senior AIDES more active participants in the civic affairs of their communities. Many have already participated in the Older American White House Forums—held last September—as well as public safety and other activities.

D. Senior Community Service Programs [6]

Across the Nation from Maine to California, 572 low-income elderly persons earn badly needed income in 11 Senior Community Service projects, sponsored by the National Council on the Aging. In July, the program was extended with $1.35 million in funding from the Department of Labor. Particularly noteworthy was the work performed by four aides at the Social Security office in Trenton, New Jersey. In reviewing the vital statistics of 3,000 persons, the aides found that

[5] Senior AIDES is an acronym for Alert, Industrious, Dedicated, Energetic Service. The program is sponsored by the National Council of Senior Citizens.

[6] To be eligible for the Senior Community Service programs, an applicant must (1) be 55 or older, (2) have an income within the OEO poverty index, (3) be retired or unemployed for 15 weeks or longer, (4) have no other reasonable expectation of other employment or training, and (5) reside near the job site.

nearly 9 percent of these individuals were entitled to benefits which they were not receiving.

From Huntington, West Virginia, this assessment was made of the work habits of the elderly participants:

—They have a deep sense of responsibility;
—Older persons are especially reliable and have a definite desire to work;
—Elderly participants require less supervision;
—They have a serious attitude toward work;
—Older Americans are willing to work extra hours and without pay; and
—They are very punctual.[7]

For many participants, their work as part-time community aides has provided a stepping stone for permanent, full-time work in government or private industry. For example, 10 nutrition outreach aides at the Maine project have moved onto the permanent payroll of the Extension Service of the University of Maine.

E. Senior Community Service Aides

Sponsored by the National Retired Teachers Association-American Association of Retired Persons, the Senior Community Services Aides program was established in August 1969 to demonstrate the best ways to recruit, train and find permanent, part-time jobs for low-income persons 55 and older. Enrollees are paid $1.60 to $3.00 per hour while undergoing training during a 40-week period. Average annual income for enrollees is about $1,140, but 126 reported no income at all.

Project sites include Atlanta, Ga.; Cleveland, Ohio; Jacksonville, Fla.; Kansas City, Mo.; Louisville, Ky.; and St. Petersburg, Fla.

Physically handicapped persons account for 72 of the enrollees, and their performance has been outstanding. They have required very little attention and have clearly demonstrated their abilities to perform vital services. For example, a legless former schoolteacher has worked as a recruiter—and, in some cases, door to door in his wheelchair. An elderly Cleveland lady, with arthritically deformed hands, performs clerical duties in maintaining records.

According to the latest data available, 107 persons completing training have been placed in permanent, part-time community service employment. In addition, 174 have been placed in the private sector. During the past 16 months, approximately 600 older men and women have been returned to the mainstream of labor with meaningful employment opportunities and training.

F. Virginia State College

Located in Petersburg, Va., the Virginia State College program provides job opportunities for older persons in beautification, employment referral, health and outreach activities. The average age of the participants is 64. Their average annual income prior to enrollment amounted to about $1,000.

Participants work 20 hours a week, and can earn $1,600 a year. In 1970, the program was renewed for 9 months, through March 31, 1971.

[7] Excerpted from *Aging*, Sept.–Oct. 1970, p. 11.

III. JAVITS-NELSON AMENDMENT

During the consideration of the fiscal 1971 Labor-HEW Appropriations bill (H.R. 18515), Senators Javits and Nelson offered an amendment to raise the new obligational authority for work and training programs under the Economic Opportunity Act by $41.9 million more than recommended in the House-passed bill. In his floor remarks, Senator Javits noted that this funding could provide training opportunities for an additional 33,950 enrollees.[8]

Of particular significance for the elderly was a $2.2 million increase for Mainstream, raising the House recommendation for $38.8 million to $41.0 million. Expressing strong support for the amendment, Senator Williams added:

> This badly needed funding can help provide new employment opportunities for large numbers of older workers.
>
> It can also be used to expand some of the successful pilot projects under Mainstream—such as Green Thumb, Senior AIDES or the Senior Community Service programs.
>
> And it can help many disadvantaged older workers back to the road of financial recovery.[9]

The Senate approved the amendment by a vote of 42 to 32. But, in Conference Committee, the $41.9 million increase was deleted.

With the unemployment rate reaching its highest level in 9 years, older workers—and especially the disadvantaged aged—are finding it increasingly difficult to locate work. For the long-term jobless, Mainstream has literally been a lifesaver. For the coming fiscal year, the Committee urges full funding of Operation Mainstream to provide increased employment opportunities for the chronically unemployed poor who have limited prospects for jobs because of age or other disadvantages.

IV. OTHER OEO PROGRAMS AND CONTRACTS

Regardless of the urgent need to raise the income levels of the elderly poor, a growing demand also exists for providing supportive services directed at their special problems. Again in 1970, a number of OEO funded demonstration programs helped to provide aged persons with information and counseling on matters of direct benefit to them. Additionally, program guides were prepared for community action agencies to help improve services for elderly poor.

A. Project Late Start[10]

Late Start is designed to provide a new start toward independent living for disadvantaged older persons. Beginning its second year of operation, the program is located in four cities—Augusta, Maine; Toledo, Ohio; Charlotte, N.C.; and Brownsville, Tex.

There are four, 10-week cycles for 5 days a week in which low-income older persons participate in a series of specially designed discus-

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[8] Nov. 20, 1970, Cong. Rec., p. S18620.
[9] Debate cited in footnote 8, p. S18621.
[10] Project Late Start is sponsored by the National Retired Teachers Association-American Association of Retired Persons.

sion groups, guidance sessions, lectures and demonstrations. Hot meals and preventive medical and health services are also provided for participants.

Instructors inform Late Start enrollees about the availability of programs and services for them, employment opportunities, consumer matters, and housing to enhance their self-sufficiency. Other goals of the program include:

—Developing latent skills and interests to provide enrollees with opportunities for helping others, either as a paid employee, volunteer, or just an informed friend.
—Bringing isolated individuals together to provide opportunities for social contact and a means of giving each person mutual help.
—Raising the level of involvement in the community.

Last May the program was extended for 1 year with $252,000 in Federal funding. Approximately 650 enrollees participated in the experimental project in 1970.

B. Project WORK [11]

Project WORK is an acronym for Wanted Older Residents with Know-how. Now in its third year, the program has basically three major components: (1) Job referral and development; (2) outreach activities; and (3) correlation with OEO neighborhood centers to encourage elderly poor persons to participate in programs which will be of particular benefit to them.

Despite the high unemployment rate (7.3 percent) in Long Beach, California, Project WORK succeeded in placing approximately 50 applicants, aged 55 and over, in productive jobs. Placements were divided equally between part-time and full-time employment, including day care aides, handymen, and clerical positions.

Outreach activities range from suicide prevention to helping individuals become certified for food stamps. In one case an aide helped rescue a diabetic in a coma by taking the patient to a hospital.

C. NCOA Monographs

Another significant development in 1970 for OEO was the preparation of five technical assistance monographs by the National Council on the Aging for the Senior Opportunities and Services programs. Three major purposes of the papers were: (1) To provide helpful program guides for senior opportunities centers and community action agencies; (2) to help elderly persons who may wish to initiate self-help projects; and (3) to provide greater information about the needs and desires of the elderly.

COMMUNITY ORGANIZATION, PLANNING AND RESOURCES AND THE OLDER POOR

This monograph—based on papers presented at Regional Training Institutes and Workshops of NCOA—is designed to provide the anti-poverty worker with a framework for better understanding his community and to offer concrete and creative techniques for utilizing its

[11] Project WORK is sponsored by NRTA–AARP in Long Beach, Calif.

resources. Throughout the monograph is a reappearing theme that the problems of the elderly are also the problems of the total society. Consequently, all persons in a community—the young as well as the old—have an important stake in working together to solve their problems.

The monograph also emphasizes that the role of the community organizer in the field of aging must be special, since the difficulties of the elderly poor differ from those of younger persons. To create a forceful community action group of older persons, the report outlines basic tasks for the successful community organizer. Among the major roles of the organizer: (1) He must awaken in the community a desire to change the status quo; (2) the organizer must convert the community's desire for change into a desire to organize; (3) leaders who are identified with and accepted by the major subgroups in the locality must be located and involved; (4) the organizer must develop and train local leaders; (5) members of the community must be involved at the grassroots level; and (6) the organizer must develop a pace of operations for the organization consistent with the capabilities of the community.

Another key point is that community planning for older Americans must be more than just improving and increasing public services. A second dimension of the overall planning approach is to motivate the older person to take advantage of the services and opportunities made available to him. Mr. Glen Burch, Director of the University of California Extension Service in Davis, California, summarized the potential impact of the SOS program in this manner:

> The OEO's Senior Opportunities program potentially constitutes the most powerful force now operating in our culture to bring about a needed restructuring of the educational and social services, both professional and volunteer, at the community level. Through innovative programing, enlistment of new personnel and involvement of the old people themselves in planning and carrying out programs, we can look forward to a greatly enlarged and improved approach to community planning for aging.[12]

HEALTH, AGING, ILLNESS AND POVERTY

Also drawing information from papers presented at Regional Training Institutes of NCOA, this technical work evaluates the consequences of aging, illness and poverty. In studying the relationship between poor health and deprivation, the report notes that we have been "fighting the battle of the chicken and the egg." [13] Are the poor sick because of their poverty status or are they poor because they are sick? As pointed out in the monograph:

> Perhaps it makes very little difference. Those of us working in health fields have come to accept the idea that the "sick get poorer and the poor get sicker" and that the two are found together. As doctors, we are more interested in treating

[12] "Community Organization, Planning and Resources and the Older Poor." Senior Opportunities and Services Technical Assistance Monograph, prepared by the National Council on the Aging for the Office of Economic Opportunity, p. 64.

[13] "Health, Aging, Illness and Poverty." Senior Opportunities and Services Technical Assistance Monograph, prepared by the National Council on the Aging for the Office of Economic Opportunity, p. 28.

the twinned problems of poverty and illness than in determining the precise chronology of either. These conditions are born together, live togther, and can be made to die together."[14]

A major contribution of this paper is to outline how Medicare, Medicaid and OEO health programs can bring relief to the aged poor. Equally important, it provides the practitioner with guidelines about the elderly which can be reflected in programs established to cope with their problems.

THE PARTICIPATION OF THE ELDERLY POOR IN SENIOR CENTERS

The third NCOA technical paper provides guidelines for organizing and operating senior centers. Stressing that membership involvement is essential, the authors express concern over the exclusion of the aged from meaningful policy roles at senior centers. "Involvement", says the report, "depends on genuine participation and control over activities".[15] As a first step toward achieving this goal, the monograph recommends that the decisionmaking structure of senior programs be revised to assure the elderly an equal or dominant share of the control over planning, program or center activities, and budgeting affairs of the operation.

DEVELOPING TRANSPORTATION SERVICES FOR THE OLDER POOR

Noting that inadequate transportation is a nationwide problem, this report emphasizes that transportation difficulties for the aged have a unique dimension. Building upon the reduced fare plans in several cities, a number of other suggestions were offered to save money for the elderly rider. For example, it was recommended that special group rates be requested for older persons traveling together by taxi. Other proposals include: (1) Use Neighborhood Youth Corps enrollees to deliver grocery orders from the elderly; (2) ask ministers to have their parishes organize car pools to pick up the aged for church functions; (3) use an organization's transportation services for income-producing purposes (e.g., package delivery) to reduce operating costs; (4) ask the commander of a nearby military installation to provide voluntary drivers under the Domestic Action program of the Department of Defense.

Another aspect discussed was the need for community interest and cooperation in meeting the transportation difficulties of the aged. Among the major proposals:

—Request the sociology department of a local college to conduct a transportation survey;

—Suggest to the public transit authority that some buses be rerouted to pass through areas with a high concentration of elderly individuals;

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[14] Report cited in footnote 1, p. 28.

[15] "The Participation of the Elderly Poor in Senior Centers," Senior Opportunities and Services Technical Assistance Monograph, prepared by the National Council on the Aging for the Office of Economic Opportunity, p. 39.

—Ask doctors at clinics to arrange appointments for the aged during the hours when reduced fares are in effect and when traffic is light; and
—To celebrate Senior Citizens Month, urge the Chamber of Commerce to sponsor free transportation to special sales for older shoppers.

INVOLVING THE OLDER POOR IN THE WHITE HOUSE CONFERENCE ON AGING

The last monograph provides background information about the 1971 White House Conference on Aging. It also explains—in language that the elderly can understand—how they can play an active role in the preliminary or final conference activities. Additionally, the booklet provides a technical guide for orienting and training leaders for the preparatory conferences at the local level. And the report will be especially helpful for community action agencies, State offices of economic opportunity, and senior centers—not only in terms of suggestions for involving the elderly poor at the conferences, but also by providing proposals for preparing and encouraging the aged to participate.

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON OEO PROGRAMS

The persistency of poverty among the elderly was not universally recognized at the time of the 1961 Conference. Indeed, an optimism about the income outlook for future generations of the aged caused the conferees to consider separately their needs and the needs of those already old. Some conferees believed that most workers retiring in the future would receive private pensions as well as Social Security benefits close to the maximum. They urged that, since the problem of low income was largely transitional, primary reliance should be placed on the public assistance program rather than on social insurance. Also not widely recognized in 1961 were the potentials of part-time community service jobs in providing income for the elderly poor.

I. RECOMMENDATIONS IN 1961

In terms of program organization, the delegates stressed that a working partnership—including voluntary groups, local and State governments, and the Federal Government—would be crucial for significant and lasting benefits for older Americans. And for the elderly poor, the conferees urged sweeping changes in the adult categorical assistance programs:

—The Federal Government should provide leadership and additional matching funds for States to adopt adequate standards for public assistance payments.
—State residency requirements for public assistance should ultimately be eliminated.
—Federal matching funds should be made available to State welfare departments to develop and provide protective, rehabilitative, and social services for the aged.

II. THE RECORD SINCE 1961

Today public assistance payments still vary markedly from State to State. A Supreme Court decision has invalidated excessively lengthy residence requirements designed to deny aid for persons moving into a particular State.

An Office of Economic Opportunity was created in 1964 to provide a coordinated approach to move millions of the poor off the poverty rolls. A number of special emphasis programs have been established primarily to meet the unique problems of the aged, such as Operation Mainstream. At the urging of this Committee, a Senior Opportunities and Services program was established in 1967. And the elderly have benefitted from some of OEO's other programs, including health, nutrition, and legal services.

III. ISSUES IN 1971

Issues relating to the role of public assistance in maintaining income can be expected to receive major attention at the 1971 Conference. (For these issues, see Chapter I, Income and the Elderly.)

But many unresolved issues also exist concerning what should be the form and direction of programs serving the aged. Closely related to this issue is the administrative structure for putting drive and muscle into these programs. Quite clearly, a fundamental question for our poverty thrust in the 1970's should be: What should be the role of OEO? Should it serve primarily as an initiator of approaches to meet the problems troubling the poor? Should its role be strengthened, instead of "spinning off" successful OEO projects to other departments and agencies? Or should OEO be replaced completely with an entirely different approach and concept?

Equally important, are the issues affecting the poverty programs designed essentially for the unique problems of the aged. Should there be more earmarking to assure that the aged poor will be more fairly represented in our Nation's attempt to break the poverty cycle? Should there be statutory language or Congressional policy statements that funding for poverty programs for the elderly should be commensurate with their percentage of the total poverty population?

CHAPTER X

AREAS OF CONTINUING CONCERN

> "Problems mentioned by older citizens are not peculiar to their age groups. Their problems of small incomes, needing assistance at time of illness, needing counseling service, needing transportation around the community, are common to all people."
>
> —Elderly Participant, Public hearing on the Aging, November 17, 1970, Humboldt, Iowa[1]

Time and time again, Senators who serve on the Senate Special Committee on Aging make comments similar to the one above. They wish to emphasize that this Committee does not regard older Americans as a group set apart from the rest of the population. They do not wish to suggest that a man or woman somehow becomes a different person on the day he or she retires.

But, even though the person may remain the same person, his interest, his problems, and his hopes for the future can be changed by advancing years. In this chapter, the Committee deals with several issues which should receive consideration at the White House Conference on Aging and which will continue to receive the attention of the Senate Special Committee on Aging.

I. ELDERLY IN RURAL AREAS

The Committee continued its overall study of "Older Americans in Rural Areas" with six hearings in 1970. Testimony at the grassroots level—from the elderly, community leaders and people in the field of aging and services—was heard in Idaho and West Virginia. Two days of hearings were also held in Washington, D.C., with an emphasis on the health and housing problems of the rural aged.[2]

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[1] From report prepared by the Iowa State Commission on Aging: "Public Hearing on the Aging, Nov. 17, 1970, and other Local Activity Relating to the White House Conference on Aging, Called for November 1971: Humboldt-Dakota City, Humboldt County, Iowa. Population: Humboldt—4,590; Dakota City—706".

[2] Hearings by the U.S. Senate Special Committee on Aging, "Older Americans in Rural Areas":

Part 1. Des Moines, Iowa, Sept. 8, 1969.
Part 2. Majestic-Freeburn, Ky., Sept. 12, 1969.
Part 3. Fleming, Ky., Sept. 12, 1969.
Part 4. New Albany, Ind., Sept. 16, 1969.
Part 5. Greenwood, Miss., Oct. 9, 1969.
Part 6. Little Rock, Ark., Oct. 10, 1969.
Part 7. Emmett, Idaho, Feb. 24, 1970.
Part 8. Boise, Idaho, Feb. 24, 1970.
Part 9. Washington, D.C., May 26, 1970.
Part 10. Washington, D.C., June 2, 1970.
Part 11. Dogbone-Charleston, W. Va., Oct. 27, 1970.
Part 12. Wallace-Clarksburg, W. Va., Oct. 28, 1970.

Additional hearings are planned by the Committee for 1971. Even though the inquiry is not yet complete, a number of tentative findings have emerged from the Committee's study:

—Retirement income is generally lower for the rural elderly because of lower lifetime earnings or limited coverage under Social Security. Because of lower retirement income, the rural older American is more likely to work than his urban counterpart in order to supplement his inadequate Social Security benefits.

—Retirement patterns in rural America also differ from the trends in the cities. The withdrawal from the labor force by the urban older American is likely to be abrupt when he reaches age 65. But in rural America, retirement is usually more gradual, especially for farmers or self-employed persons who typically exercise a certain amount of managerial authority even after they cease to be active in their occupations.

—The high value for work and self-dependence also seems strongly imbedded in the rural elderly. However, the availability of jobs is dwindling with increased mechanization in agriculture and many industries leaving rural communities. Opportunities for community service employment—in such programs as Green Thumb and Green Light [3]—have been enthusiastically received by the elderly.

—Transportation inadequacies may be more intense for rural aged, especially for those without automobiles. Public transportation is frequently nonexistent, inconvenient or inaccessible when it is available.

"Transportation problems," said one witness at a hearing held in Boise, Idaho, "makes the rural aging much less mobile than the urban aging." [4]

—Many rural communities are without doctors, dentists, and nurses. And the outlook is for little improvement. Senator Vance Hartke summed up the problem this way, "The pattern is all too clear and depressing; as the rural population shrinks, so does the availability of medical services." [5] In general, the rural older American is in poorer health than the elderly city dweller. He is also more likely to be suffering from some type of chronic condition than the urban individual.

—Housing is also a serious problem for the rural homeowner whose limited income is being squeezed by rapidly rising property taxes and maintenance costs. Dilapidated housing is also a major problem. Many of these substandard homes are structurally unsafe for human occupancy or completely beyond repair.

—The hearings also confirmed the common assumption that there is a higher proportion of aged persons concentrated in rural areas than for the Nation as a whole.

In describing the impact of these hearings, Senator Frank Church declared:

> This Nation is not so rich that it can write off the future of millions of rural older Americans now past age 65 and those

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[3] Chapter VIII of this report for aditional discussion, p. 9.
[4] Hearing cited in footnote 2, statement of Mr. Herb Whitworth, Director, Idaho Office on Aging, p. 526, pt. 8.
[5] Hearing cited in footnote 2, p. 644, pt. 10.

nearing that age. This Nation is not so poor in ideas that it cannot deal with each of the problems that I have mentioned. Our hearings have emphasized the positive, as well as the problems. [6]

The Committee plans to issue a report on the rural elderly in time for the 1971 White House Conference on Aging. Because of the high percentage of aged persons in rural areas and the unique characteristics of some of their problems, this subject should receive thorough consideration by the delegates at the Conference.

II. TRANSPORTATION AND THE ELDERLY

Transportation inadequacies are intensifying many other problems encountered by older Americans. Without mobility, they find it inconvenient to shop for food, go to church, or to visit friends and relatives. No matter what the subject at Committee hearings, transportation usually emerged as a major problem. For many, it was their number two concern, just behind inadequate income and the high cost of health care. For large numbers, inadequate or inaccessible transportation was the crucial issue. And the magnitude of this problem was documented in a report [7] prepared by this Committee. A major finding of that report is that the transportation difficulties of the elderly have reached crisis proportions. In addition, the report warns that today's problems may be "worsened by living patterns already far different than those which existed when today's elderly were young." [8]

Despite the harsh reality of a crisis in mobility for the elderly, several important developments in 1970 may pave the way for significant improvements in the years ahead. An Urban Mass Transportation Assistance Act [9] was signed into law, providing for the first time a long-term Federal commitment which is essential for the development of new and improved transit facilities. Particularly significant for the elderly was a House amendment which authorizes $46.5 million for loans and grants so existing mass transit systems can be modified to meet the unique needs of the elderly and handicapped.[10] Equally important, the amendment makes it national policy for the first time that elderly and handicapped persons have the same right as other persons to utilize mass transportation facilities and services.[11]

A. Interagency Teamwork

An Interdisciplinary Workshop on Transportation and the Elderly, last May, represented not only a milestone in interagency cooperation but also a systematic effort to obtain comprehensive information on mobility of the aged. In addition, the Workshop provided a helpful dialogue—making persons in the transit industry more familiar with some of the special problems of the elderly and providing social scientists with an overview of central concepts in transit design oper-

[6] Hearing cited in footnote 2, p. 522, pt. 8.
[7] U.S. Senate Report No. 91–1520, "Older Americans and Transportation: A Crisis in Mobility," December 1970, by the Special Committee on Aging.
[8] Report cited in footnote 7, p. 2.
[9] Public Law 91–453, Oct. 15, 1970.
[10] Report cited in footnote 7, pp. 50–51 and 111–113.
[11] See sec. 8 of Public Law cited in footnote 9.

ations and economics. And it provided an opportunity to evaluate existing techniques, identify gaps in service, and give directions for future research and demonstration.[12]

B. President's Task Force

Recognizing that transportation problems accentuate the isolation of older Americans, the President's Task Force on Aging concluded that "it is as important for the Nation to develop or have developed special transportation arrangements for older persons as it is for the Nation to meet their income, health, and other needs." [13] Additionally, the Task Force recommended that OEO and the Departments of Transportation, HEW and HUD undertake an intensive inquiry into all aspects of transportation as it affects the lives of the aged.

C. Committee's Transportation Report

A comprehensive and far-reaching 12-point program was urged by this Committee in the transportation report to meet the short-term as well as the long-term problems. Recommendations ranged from a special emphasis transportation services demonstration program for older Americans to full implementation of the Urban Mass Transportation Assistance Act and the House amendment mentioned earlier.[14]

The Committee again urges that the 12-point plan—proposed in its Transportation Report—be acted upon promptly and favorably by congressional units and Federal agencies.[15]

III. ELDERLY MEMBERS OF MINORITY GROUPS

A major development in 1970 was the formation of the National Caucus on the Black Aged in November.[16] Its major purposes are to (1) help close the significant gaps related to services, research and training for the needs of the aging and aged blacks and (2) call national attention to the plight of these individuals.

Unavailability of adequate data has presented a serious problem in attempting to describe the dimensions of the aged blacks' problems as well as attempting to provide a basis for solutions. To help provide this badly needed data, the National Caucus on Black Aged has requested the Social Security Administration to prepare a special report focusing upon aging and aged Negroes to help close some of the present information gaps. It was also urged that this report be prepared as soon as possible to provide data for the delegates to the White House Conference on Aging.

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[12] Report cited in footnote 7, p. V.

[13] "Toward a Brighter Future for the Elderly," Report of the President's Task Force on Aging, April 1970. p. 41.

[14] Report cited in footnote 7, pp. 50–51.

[15] For discussion of recommendations made in report, see pp. 47–57, report cited in footnote 7.

[16] The National Caucus on Black Aged is an organization of citizens concerned with the plight of older black Americans. The group held its first meeting prior to the 106th anniversary celebration of the Stephen Smith Home for the Aged, 4400 West Girard Avenue, Philadelphia. Hobart C. Jackson, director of the Smith Home and a noted authority in the field of aging, was named chairman. Other participants represent the fields of social work, sociology, social welfare, housing administration, community organization, nursing and psychology.

Another issue of concern is that—because of the shorter life expectancy for Negroes—there is a greater likelihood that a black aged person will not receive his Social Security benefits or draw benefits over a proportionately shorter period than white older Americans. The National Caucus acknowledged that black older Americans may receive proportionately higher Social Security benefits in terms of their contributions to the system than the white aged. But at the same time, they have been paying more proportionately in taxes from their total income than the white elderly because of the regressive features in the Social Security tax structure.

Current data on the black aged and other minority groups [17] is very sparse. But if a national policy for all older Americans is to be formulated, this information will be essential to take into account the unique problems of minority groups. The Committee urges that the Social Security Administration prepare a special report, as expeditiously as possible, on the characteristics of aged recipients from minority groups.

IV. OPPORTUNITIES FOR THE PRIVATE SECTOR

In 1970, the Committee on Aging began hearings on "Sources of Community Support for Federal Programs To Serve Older Americans." [18]

Three major objectives of this inquiry were to (1) explore ways in which nonprofit groups can help provide more services and facilities than are now available for the aged; (2) determine whether Federal policies are discouraging private organizations from assuming a more active role in behalf of the elderly; and (3) receive suggestions for developing community support for projects serving the older Americans, and the proper role for Federal agencies in these activities.

Equally important was the recognition by practically all witnesses—whether they represented nonprofit agencies or governmental units—that the Federal Government needs help from private sources if its programs for the elderly are to be successful.

"To win that assistance," Senator Harrison A. Williams declared, "the Congress and the Executive Branch must exercise some leadership, great tact, and deep understanding." [19]

Throughout the hearings, several areas of immediate concern began to emerge:

—Many nonprofit sponsors experience great difficulty in launching programs because of bureaucratic redtape. The problem of "grantsmanship" is all too familiar, especially for those groups representing minorities.

[17] The Senate Committee on Aging, in 1968 and 1969, conducted hearings on the "Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans" and is now summarizing findings from this testimony and other sources of information. In early 1971, a survey of elderly American Indians was begun. Several other possible areas of study are contemplated.

[18] Hearings by the U.S. Senate Special Committee on Aging, "Sources of Community Support for Federal Programs Serving Older Americans":
Part 1. Ocean Grove, N.J., Apr. 18, 1970.
Part 2. Washington, D.C., June 8–9, 1970.

[19] Hearing cited in footnote 18, p. 116, pt. 2.

—Some difficulties are caused by apparent indifference on the part of some program administrators. Others are caused by weaknesses in Federal authorization legislation passed by Congress.
—And a serious barrier is caused by the lack of adequate appropriations to launch or continue programs to serve the elderly. A prime example—mentioned time and time again at the hearings—was the phasing out of the popular Section 202 rental housing program for the elderly, although the Congress expressed its enthusiastic support for this approach by authorizing $150 million for this purpose.[20]

In addition, the Committee on Aging requested appropriate Federal agencies to provide (1) descriptions of programs they administer for the elderly in layman's language and (2) information on how nonprofit sponsors can qualify for Federal assistance. In the HUD report, entitled "How Nonprofit Sponsors Can Help Provide Housing and Related Facilities for the Elderly Under HUD Programs," [21] these basic considerations were listed for a successful housing project:

—a suitable site, within walking distance of shopping facilities, if possible, and near to churches, medical facilities, or convenient transportation to these amenities;
—proper planning and design;
—good public relations with the community, and with the prospective clients;
—adequate management provisions that assure sound operation.

During this year, the Committee plans to prepare a report to help nonprofit sponsors understand the procedures to qualify for Federal assistance to help serve the elderly.

In preparing for the White House Conference on Aging, the Administration on Aging has taken pains to invite private organizations to take an active role before, during, and after the Conference.

However, the AoA and other Federal agencies should recognize—as shown by preliminary inquiries by this Committee—that many potential nonprofit sponsors associated with such national organizations feel that much more can and should be done to develop more viable rapport between government and the private sector.

Unless the White House Conference is successful in generating at least the hope or belief that such rapport can be established, it will have failed in reaching an essential objective.

V. MENTAL HEALTH CARE AND THE ELDERLY

Mental health—described as "adaptability to internal and external change, recognition of self-limitations and potential, and the maintenance of a variety of sources of satisfaction" [22]—received extensive

[20] See Chapter III of this report for additional details.
[21] Prepared by the Department of Housing and Urban Development, at the request of this Committee, to be published in 1971.
[22] "The 1961 White House Conference on Aging: Basic Policy Statements and Recommendations," prepared by the Special Committee on Aging, May 15, 1961, p. 42.

attention at the 1961 White House Conference on Aging. Among the recommendations that emerged were:

—development of a public enlightenment program which recognized that public attitudes can and must be changed.
—that mentally ill aged should not be precluded from the same agencies and clinics serving other groups, and that there should be free movement between in-patient and out-patient services.
—that a proper psychiatric evaluation of any patient be conducted before initiating commitment proceedings.
—that a percentage of all Federal hospital construction funds be earmarked by the States for mental health facilities.

In the near-decade which followed publication of those recommendations major changes have occurred, and they are changes which should have resulted in greater availability of mental health services for the elderly. Given Federal support, the community mental health center program burgeoned. Medicare and Medicaid made limited provision for mental health services. In State institutions and in nursing homes, experiments in rehabilitative techniques gave at least the promise of reduced institutionalization and greater opportunity to "return to the community."

And yet, concern about mental health needs of the elderly may be even more intense now than it was at the time of the 1961 Conference. The Senate Special Committee on Aging—in research conducted for a forthcoming report on alternatives to institutionalization, as well as improvements in the care of those who must remain in institutions—has gathered a considerable amount of evidence indicating that (1) positive efforts to return elderly patients to the community can result in success if they are not physically depleted by combinations of illness which so often afflict residents of State hospitals, (2) that a strikingly high percentage of residents in nursing homes have mental disability, but that often their condition is not recognized or treated, and (3) that the need for hospitalization may increase, not decrease, as the number of persons in their 70's, 80's, and even 90's continues to increase.

A. The G.A.P. Report

A major expression of concern about the problem was made in November 1970 by the Committee on Aging of the Group for the Advancement of Psychiatry.

The G.A.P. report declared: [23]

—Severe restrictions and major defects in Medicare and Medicaid limit their helpfulness to the elderly.
—The potential of comprehensive mental health programs, from home care to institutions, has not been realized.
—The "return to the community" from a State hospital is often merely a transfer to inadequate custodial facilties.
—Americans aged 65 and over make up 9.7 percent of the population but account for 25 percent of the annnual admissions to mental hospitals.

[23] "Toward a Public Policy on Mental Health Care of Elderly," Vol. VII, Report No. 79, of the Group for the Advancement of Psychiatry, 419 Park Avenue South, New York City. The G.A.P. is described as an independent group representing approximately 200 psychiatrists. Chairman of the Committee on Aging is Dr. Jack Weinberg, Chicago, Ill.

—Thus, the elderly suffer disproportionately from our system of noncare, characterized by insufficient financing for both health and sickness and by fragmented delivery of services.

The G.A.P. report, said its authors, was offered "in anticipation of the 1971 White House Conference." [24] Its major recommendations were:

—Establishment of a Presidential Commission to make recommendations toward a national policy for the prevention, care and treatment of mental illness among aging and retired Americans. The Commission would provide an interim report before the 1971 White House Conference on Aging but would continue in existence afterwards.
—Universal prepaid comprehensive health insurance.
—Broadening of Medicare coverage to include coverage for mental illness at levels comparable to those for physical illness.
—Upgrading of Medicaid standards and opposition to Medicaid cutbacks.
—Development of comprehensive diagnostic and treatment centers in conjunction with existing health resources.
—Several steps to protect the legal rights of older patients.
—Broadened research effort.

B. President's Task Force

Like the Group for the Advancement of Psychiatry, the President's Task Force on Aging called in 1970 for a Commission on the Mental Health of the Elderly. It also recommended that: "the restrictions in Medicare coverage on out-patient psychiatric care be removed so that Medicare pays the same benefits for out-patient psychiatric treatment as it does for all medical care." [25]

In addition, the Task Force recommended that the 190-day lifetime limitation under Medicare for inpatient treatment in a psychiatric hospital be removed.

In its discussion of Medicare, the Task Force referred to limitations under that program as "an archaic throwback" [26] in the treatment of emotional problems.

Issues raised by the President's Task Force and by the Group for the Advancement of Psychiatry should receive careful attention by qualified practitioners and by representatives of laymen before the 1971 White House Conference on Aging in a manner going far beyond the mere discussion of technical papers by technical review committees and task forces now at work in preparation for that Conference. The G.A.P. proposal for an interim report by a presidential commission may be the most practical approach. Congress should weigh the advisability of a legislative mandate calling for such a commission and such an interim report.

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[24] Report cited in footnote 23, p. 660.
[25] Report cited in footnote 13, pp. 33–34.
[26] Report cited in footnote 13, p. 33.

VI. SOCIAL SERVICES FOR THE ELDERLY

Contrary to popular stereotypes, the typical older American is not a doddering patient in an institution. Only about 1 million—or one out of every 20 elderly persons in the United States—are institutionalized. But another 1 million are homebound, and nearly 5 million live alone. For many of these individuals, social services can mean the difference between living in their own homes rather than in a nursing home or other institutions at a greater public expense. And for other individuals, social services can be a means for counteracting isolation, loneliness, and despair.

A. Services Under Older Americans Act

Again in 1970, the services provided under the Title III program [27] of the Older Americans Act proved to be a prudent investment—not only for the individuals helped but also for the Federal Government. Even with the limited funding available for these projects, more than 165,000 elderly were helped to maintain independent living arrangements. Telephone reassurance calls and friendly visitation services gave a new sense of security to thousands. Homemaker or home maintenance services helped many maintain their own independence in familiar and friendly surroundings, and at a considerably less cost than the more expensive alternatives of hospitalization, nursing home care or other forms of institutionalization. And Meals on Wheels provided nutritious food at an average cost of $1.25 per meal.

B. Broadened Requirements Under OAA

A major development in 1970 was the issuance of regulations by the Social and Rehabilitation Service on "Service Programs for Aged, Blind, or Disabled Persons." One significant change provided that State adult categorical assistance plans must provide for homemaker services by April 1, 1974 to be reimbursed at a 75 percent level by the Federal Government. Such services would include home maintenance, home management, and personal care services for adults who are determined by the State agency to need this assistance. Moreover, the new regulations provide for additional special services for the blind, such as counseling or safety devices.

Welcome as the upgrading of social service requirements may be, it should be remembered that the regulations apply—in terms of the elderly—only to those two million now receiving Old Age Assistance.

C. "Fragmentation" Still the Rule

Today the delivery of services to the elderly is still largely fragmented and haphazard. Gaps exist because of lack of systematic planning and coordination. Emphasizing the need for a comprehensive approach and a partnership between the public and private

[27] Title III—Grants for State and Community Programs on Aging, Older Americans Act of 1965, as amended, Public Law 89-73, July 14, 1965.

sectors, U.S. Commissioner on Aging, John B. Martin, told a Technical Committee for the White House Conference on Aging:

> There can be little doubt, in my judgment, that older people need a spectrum of services. Nor do I have doubt that Government and voluntary and private agencies must combine their resources to provide them.[28]

Closely related to this overall problem is the critical shortage of trained personnel to provide the services needed by the elderly.[29] Training for social service workers, it has been suggested, should be doubled in the next 5 years. And there is an equally pressing need for homemakers, home health aides, and counselors.

Despite the passage of the Older Americans Act 5 years ago, services for the elderly still continue to be fragmented. And existing successful programs face the prospect of wholesale termination when Federal funding ends, since many States lack the necessary resources to continue these vital services. Because of the complexities of the issue and its overriding concern to the elderly, the Committee urges that delegates at the 1971 White House Conference on Aging recognize the vital need to develop a sound and coordinated approach for the organization and delivery of social services for the aged. An "income strategy," even one which provides truly adequate economic security for the elderly, will not eliminate the need for service delivery systems far superior to any that now exist.

VII. MODEL CITIES AND THE ELDERLY

In 1966, when the Model Cities program was first launched, members of this Committee expressed high hopes that it could contribute significantly to improving the lives of the elderly. The Committee recognized that older Americans comprise a disproportionately high percentage of the population in central cities. In addition, the program represented a comprehensive approach to many of the aged's problems—housing, income, health, employment, and transportation.

In 1970, high level officials from the Department of Housing and Urban Development and the Administration on Aging also emphasized the great potential of the program for the elderly. For example, AoA Commissioner John B. Martin declared:

> Therefore the Model Cities program offers great possibilities for improving their lives *but only if* advocates for the elderly are active in local urban planning and program operation. We need three things: visibility of need; technical assistance; and a cooperative effort at the State and community level involving the same kind of meshing of objectives and pooling of resources as now exists at the Federal level. We must make certain that there is a deeply concerned advocate for older people on every board and committee involved in the program.[30]

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[28] Statement by the Honorable John B. Martin, Special Assistant to the President for the Aging, and Director for the 1971 White House Conference on Aging, delivered to the Technical Committee on Facilities, Programs and Services, Jan. 7, 1971. Washington, D.C., p. 3.
[29] For further discussion on training, see p. 135, Chapter XI of this report.
[30] Release by U.S. Department of Health, Education, and Welfare, Model Cities and Aging Workshop, Seattle, Wash., Jan. 14, 1970, p. 2.

In July 1970, HUD and AoA entered into a joint contract with the National Council on the Aging to provide technical assistance in programing for older persons in 21 Model Cities. This undertaking will include (1) organization of the elderly to facilitate their involvement in Model Cities programs, (2) evaluation of existing programs, (3) assistance in implementing programs which have already been funded, and (4) assistance in coordinating resources.

Additionally, a joint Model Cities Administration and Aging Workshop was held last January in Seattle to discuss how the Model Cities program could best serve the needs of the elderly. Keynoting the 3-day Conference, Commissioner Martin said:

> This workshop represents the culmination of months of cooperative effort by the Administration on Aging of the Department of Health, Education, and Welfare, and the Model Cities Administration of the Department of Housing and Urban Development to extend the promise and reality of Model Cities services and opportunities to older Americans.
>
> It is important to thousands of older people throughout the country. If successful, we shall have taken a major step toward improving the lives of many of today's older people and will have moved toward creation of model community life in the 21st century.[31]

But great uncertainty characterized the Model Cities program in 1970. The President's Task Force on Model Cities noted that the program experienced problems because it "has been both over-regulated and under-supported".[32]

Though the Administration was prepared to announce procedural changes to remedy the "over-regulation", it was not prepared to request more adequate funding. And Administration plans to divert Model Cities funds to help desegregate school systems also raised serious questions about the Administration's commitment to the program.

Uncertainty of commitment continues to hamper the Model Cities program. Responses to a questionnaire prepared by the Committee also indicate inadequate funding threatens the very existence of the program.

The Committee renews its strong support that the Model Cities program be continued. In addition, the Committee will hold further hearings on the "Usefulness of the Model Cities Program to the Elderly" and issue a report later in the year.

In addition, White House Conference on Aging Task Forces on Housing, on Environment, Transportation, and Services should develop mechanisms by which the full potential of the Model Cities program—or a truly adequate successor program—can be explored.

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[31] Release cited in footnote 30, p. 128.
[32] Wall Street Journal, Sept. 30, 1970.

CHAPTER XI

THE ROLE OF AoA—OR A SUCCESSOR

Every older American, no matter what State in which he lives, now has an agency within his State to represent him.

That became the situation, for the first time in our history, last year when the U.S. Administration on Aging approved State plans in Indiana, Alabama, and Wyoming, the last three States to qualify for funds under the Older American Act of 1965.

In many other respects, 1970 was a significant year:

—It marked the fifth anniversary of the Older Americans Act and the Administration on Aging established under that Act.

—More than 800,000 Older Americans, speaking out at the grassroots, participated at 6,000 "speak-out" forums conducted last September as the opening events for this year's White House Conference on Aging.

—And in Washington, AoA planners developed a plan which called for three stages in the White House Conference: a year in which the elderly were heard (1970); a year to conduct the White House Conference and preliminary Conferences in each State (1971); and a year for implementation of Conference recommendations (1972).

—1970 was also significant because a Presidential Task Force on Aging proposed new and important recommendations going far beyond proposals offered by the existing and former administrations.[1]

But, once again, concerned deepened about the very future of the Administration on Aging.

For example, in the view of many specialists in aging, the decentralization of the Title V (Training) programs to the 10 Social and Rehabilitation Service regions represented another move to downgrade AoA. Large numbers expressed fears that competition with other SRS programs would reduce appropriations for training in the field of aging.[2] Others argued that this action violates the intent of Congress as expressed in authorization legislation. Similar misgivings were also raised about the decentralization of the Foster Grandparent program.[3]

In the view of the Presidential Task Force, the organizational structure of the programs for the elderly represents the "key" to responding to the problems, challenges and hopes of an aging population. Placing primary emphasis on this problem, the Task Force declared:

> If the Nation is to achieve the goals set forth in the Older Americans Act, the Task Force believes that present efforts of the Federal Government on behalf of the elderly should be organized more effectively. The success of some of the new programs it recommends can be accomplished through restructuring such efforts.[4]

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[1] For a summary of the Task Force Proposals, see app. 2, p. 311.

[2] These fears were confirmed in the fiscal year 1972 budget. Requested funding for Title V training was cut back from $3 million in fiscal 1971 to $1.85 million.

[3] The fiscal 1972 budget requests only $7.5 million for the Foster Grandparent program, $3 million below the fiscal 1971 appropriation of $10.5 million.

[4] "Toward a Brighter Future for the Elderly," the Report of the President's Task Force on the Aging, April 1970, p. 12.

I. FUNDING PROBLEMS IN 1970

Important as the authorization process is for establishing broad Congressional policy, it is the actual funding which determines, to a very substantial degree, the success or failure of earlier hard-won legislative victories. Again in 1970, the struggle continued for adequate appropriations for programs for the aging.

A. Struggle: But Some Limited Victories

In early 1970 the funding battle lines were drawn when the Administration submitted its budget for fiscal year 1971 (July 1, 1970 through June 30, 1971). For the present fiscal year, the Administration recommended $32 million for the Older Americans Act and $1 million for the White House Conference on Aging, approximately 37 percent of the total authorized funding for both laws. Of this total, $31 million was earmarked for programs under the Older Americans Act and $1 million for the White House Conference.

For the Older Americans Act, the new budget request represented approximately a $1 million cutback in funding compared with fiscal 1969—although there was a growing demand for research, training, and community programs to serve the elderly. When questioned specifically about the reduction in funding for the Title III State and Community Programs on Aging, Mr. John Twiname, Administrator for SRS, replied:

> Thus the Title III program, while recognizing the inevitable consequences of fiscal hardship, is accomplishing as much as possible within the required limitations.[5]

Request for fiscal year 1971

Authorization legislation	Authorization	Appropriation request
Older Americans Act:		
Grants for State and community programs on aging	$25, 000, 000	$9, 000, 000
Planning, coordination, and evaluation and administration of State plans	5, 000, 000	4, 000, 000
Areawide model projects	10, 000, 000	2, 200, 000
Research and development projects, and training projects	15, 000, 000	5, 800, 000
Foster Grandparent Program	20, 000, 000	10, 000, 000
Retired Senior Volunteer Program	10, 000, 000	0
Total	85, 000, 000	31, 000. 000
White House Conference on Aging (Public Law 90–526)	1, 900, 000	1, 000, 000
Total	86, 900, 000	32, 000, 000

[5] Departments of Labor, and Health, Education, and Welfare Appropriations for Fiscal Year 1971, hearings before the Subcommittee of the Committee on Appropriations, U.S. Senate, p. 3927.

Williams-Prouty Proposal.—With widespread support from numerous aging organizations, Senators Harrison Williams and Winston Prouty led a bipartisan drive in June for increased funding. Testifying before the Senate Labor-HEW Appropriations Subcommittee, they recommended raising the budget request for the Older Americans Act from $31 million to $45.355 million.

In summing up the effects of these proposals, Senator Williams noted:

> This is a modest increase considering the urgent needs, but I believe it is realistic in view of the budgetary situation. The benefits from such an undertaking would be many:
> —New opportunities for community service for lonely elderly persons;
> —More services for individuals in need;
> —Additional studies to obtain more information and knowledge about our 20 million older Americans; and
> —More trained personnel to provide the care and service needed by the aged.[6]

In addition, the Senators urged a $600,000 increase in appropriations for the White House Conference on Aging to cover delegate expenses. The effect of the proposal would be to raise the Administration request of $1 million for fiscal 1971 to $1.6 million. Senator Prouty pointed out:

> This is clearly an essential component of the Conference budget. Delegate attendance is quite obviously essential to the success of the Conference, and it is unrealistic to expect delegates to pay their own way. Many delegates will be older persons with small incomes. The attendance at the Conference of older people from all income levels is essential to its success. Their participation will insure a truly open and representative Conference in which older people themselves can have a role in shaping national policy on the aged.[7]

Legislation	Administration request	Williams-Prouty proposal
1. Older Americans Act:		
State and community programs on aging	$9, 000, 000	$16, 000, 000
Research and development	2, 800, 000	4, 155, 000
Training	3, 000, 000	4, 000, 000
Retired Senior Volunteer Program	0	5, 000, 000
2. White House Conference on Aging	1, 000, 000	1, 600, 000

Congressional Action.—On July 28 the House of Representatives approved the Labor-HEW Appropriations bill, adopting the Administration's request of $32 million for the Older Americans Act and the White House Conference on Aging. This amount was later raised to $34 million by the Senate Appropriations Committee. An additional

[6] Hearings cited in footnote 5, p. 37.
[7] Hearings cited in footnote 5, p. 30.

$1 million was provided for the Foster Grandparent program—increasing the Administration's request from $10 million to $11 million. The Committee also recommended $1 million for RSVP. But the Committee deferred action on funding for delegate expenses for the 1971 White House Conference on Aging until the next fiscal year.

Funding for Delegate Expenses.—When the appropriations measure was considered by the Senate in November, Senators Williams, Church, Mondale, Prouty and Randolph emphasized that funding was needed now to assure the elderly that money would be available to pay for their delegate expenses for the November 1971 Conference. To help provide this assurance, the five Senators sponsored an amendment to raise funding for the White House Conference on Aging from $1 million to $1.65 million.[8]

Senator Williams noted:

> During the past 2 years, the Labor-HEW appropriations bills have been considered in the Senate in November and December. If this occurs next year, it would be impossible for the States to assure their elderly delegates that their travel expenses will be covered.[9]

Senator Frank Church stressed that many elderly persons would be precluded from participating unless money would be available:

> Without such assistance, many older Americans will not be able to attend—particularly low-income persons or individuals who would be required to travel great distances.
>
> In my State of Idaho, older persons will be required to travel nearly 2,500 miles to participate in the Conference. This will, of course, require a substantial outlay, which persons living on fixed incomes could not hope to undertake.[10]

The amendment was adopted without a dissenting vote, increasing the appropriations in the Committee bill for programs for aging from $34 million to $34.65 million.

Fiscal 1971 Labor-HEW Appropriations Law.—In Conference Committee the funding in the Senate-passed bill was reduced from $34.65 million to $33.65 million. RSVP was trimmed from $1 million in the Senate bill to $0.5 million, and the Foster Grandparent program was reduced from $11 million to $10.5 million. However, the additional $650,000 for delegate expenses for the White House Conference on Aging was retained in the Conference bill.

On January 11, 1971, the Labor-HEW Appropriations measure was signed into law,[11] providing $32 million for the Older Americans Act and $1.65 million for the White House Conference on Aging.

II. PROBLEMS CAUSED BY INADEQUATE FUNDING: SOME EXAMPLES

As the struggle for funds continued in 1970, the problems of many State units on aging became more intense. Severe cutbacks in services were felt throughout the Nation. New programs—such as the Re-

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[8] This would provide full funding at the authorized level of $1.9 million for the Conference, since $250,000 had been appropriated during fiscal year 1970.
[9] Nov. 20, 1970, Cong. Rec., p. S. 18624.
[10] Debate cited in footnote 9, p. S. 18625.
[11] Public Law 91-667.

tired Senior Volunteer Program, RSVP—experienced considerable difficulty in being launched. Others were forced to be maintained at earlier levels, and some were reduced sharply. Among the examples:

A. Foster Grandparent Program

The Foster Grandparent program provides part-time employment opportunities for low-income persons 60-and-over to furnish supportive service to dependent, neglected or otherwise disadvantaged children. During its 5 years of existence, the program has grown from 21 to 68 projects. Now operating in 40 States and Puerto Rico, the program concept has been expanded to serve children in a wider range of settings, including Headstart classrooms, correctional institutions, day care centers, and mental health clinics. Approximately 4,300 foster grandparents serve 8,600 children on any 1 day. Over a year's period, 5,400 elderly participants serve—oftentimes beyond scheduled working hours—22,000 different children.

Despite the indisputable success of the program, no new projects were funded in 1970. Yet, there are nearly 6 million persons 60-and-over living in poverty. Assuming that just 1 percent of this total (probably a conservative estimate) wanted to participate in the program, nearly 60,000 men and women could be providing valuable services for children in institutional settings.

But today "literally hundreds of requests for Federal help to start new projects are turned away each year for lack of funds." [12] The Committee strongly urges that appropriations be increased significantly during the next fiscal year for the Foster Grandparent program.

B. Role for RSVP

A classic example of the difficulties encountered in initiating a new program is RSVP. One of the major innovations of the 1969 Older Americans Act Amendments, RSVP is designed to provide volunteer service opportunities for persons 60 and older. These individuals would receive no pay for their services, but would be reimbursed for their meals, travel, and other out-of-pocket expenses. During hearings on the 1969 Amendments, witnesses enthusiastically supported RSVP and estimated that perhaps 1 million elderly persons would be willing to serve as volunteers in their communities. But until this fiscal year, no funding had been provided for this program.[13]

The soundness of the concept of volunteer services by older persons has been clearly demonstrated time and time again—not only for the localities served but also for the elderly participants. The Committee urges that adequate appropriations be provided for RSVP during the coming year to permit increased service opportunities for persons 60 and older. With realistic funding to cover their out-of-pocket expenses, this corps of retired volunteers can provide many valuable services, including tutoring of school children; helping elderly persons prepare their tax returns; as-

[12] Administration on Aging report, app. 1, p. 173.
[13] For more detailed discussion of funding for RSVP, see p. 184.

sisting schools as lunchroom supervisions, playground monitors and teacher aides; and rendering services in hospitals and nursing homes.

C. Community Programs on Aging: The Lifeline for Services

Perhaps the heart of the program serving the elderly, the Title III community projects provide the direct link for services as well as opportunities to serve. Again in 1970, the Title III community programs provided valuable and important services in a wide range of settings, including recreation and other leisure-type activities; friendly visitation, telephone reassurance, and home maintenance services; adult education activities; transportation services for the infirm and frail; home delivered meals; and homemaker and home health services.

Despite a $25 million authorization, only $9 million was requested and appropriated for the State and community grant programs on aging (section 301 of the Older Americans Act). Compared with the fiscal 1969 funding level this represented a $5.5 million reduction, at a time of an increasing demand for new projects. Moreover, the new appropriations will fund only about 700 community projects, nearly 400 fewer than in 1969.

Recent cutbacks in funding for community programs on aging represent a serious setback for elderly persons in need of supportive services. In terms of cost savings, this reduction appears to be shortsighted. Services under these projects have been provided economically and efficiently. Furthermore, these services have enabled thousands of elderly individuals to remain in their homes, rather than being institutionalized at a much higher public cost.

D. Research and Demonstration: A Critical Shortage

Solutions for many "aging" problems are apparent, but oftentimes elusive. For the more elusive questions, answers must be sought through applied research and demonstration. However, the low priority for aging research and development still continues to be a problem. During 1970, $2.8 million was requested and appropriated for Title IV R & D programs, nearly $1.355 million less than in 1969. This amount is expected to fund 52 projects, about 17 fewer than in 1969. Lack of a clearcut national policy has also added to the problem. And the lack of established priority needs for research—as well as defined goals—has been a contributing factor.

Yet, important but still unanswered questions about growing old present compelling reasons for expanding research and demonstration efforts. Understanding and learning how to deal effectively with the inevitable aging process is crucial for all Americans—the young as well as the old. Moreover, R & D efforts in aging, limited though they have been, have repeatedly proved to be a sound investment.

The Committee expresses strong support for the Tack Force on Aging's recommendations for stepped-up funding for Title IV (Research) and Title V (Training) of the Older Americans Act.[14]

[14] For more detailed discussion of the Task Force's recommendations, see p. 53 of report cited in footnote 4.

In addition, the Committee urges the establishment of a national policy for aging research and demonstration—with clearcut goals and profits.

E. A Dearth of Trained Personnel

A critical shortage of trained personnel continues to be one of the most pressing problems for expanding and providing services for the elderly. It is estimated that less than 20 percent of all individuals employed in programs serving the elderly have had formal preparation for their work.[15] Projections for future demand place requirements for trained personnel in 1980 "at a level two and three times above that of 1968." [16] But the $3 million for the Title V training programs in 1970—though a slight increase over previous years—falls far short of meeting the documented need.

Federal leadership is also essential if older Americans are to be served by competently trained persons. In addition, a dynamic and comprehensive national training program is urgently needed—as recommended in "The Demand for Personnel and Training in the Field of Aging"—not only to meet existing demands but future ones as well. From an economic standpoint additional funds for training would be a prudent national investment in terms of insuring that a greater proportion of retirees will be healthy, independent adults.

III. RECOMMENDATIONS OF THE PRESIDENT'S TASK FORCE ON AGING

Completed in February, the President's Task Force report—"Toward a Brighter Future for the Elderly"—proposes 24 far-reaching recommendations, ranging from income maintenance and health care to governmental organization and transportation.

A. Executive Office on Aging

Heading the list was a strong recommendation for more efficient means for organizing programs affecting older Americans. Among the reasons given for this "number one" concern:

—Several units in Government are engaged in a wide range of activities directly or indirectly affecting the aged in a variety of ways.

—Lack of coordination at the national level constitutes a major problem for Federal agencies administering programs for the elderly.

—No Federal agency has authority to determine priorities; settle jurisdictional conflicts; eliminate duplication; identify and assign responsibility; and make other important decisions.[17]

To provide for more effective coordination, the Task Force urged the establishment, either by statute or executive order, of an Office on Aging within the Executive Office of the President. The functions

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[15] "The Demand for Personnel and Training in the Field of Aging," report prepared for AoA by Surveys and Research Corporation of Washington, D.C., July 1969, p. viii.
[16] Report cited in footnote 15, pp. viii–ix.
[17] Report cited in footnote 4, p. 12.

of this new office would include: (1) Developing a national policy on aging; (2) overseeing the planning and evaluation of all Federal activities relating to aging; (3) coordinating these activities; (4) recommending priorities to the President; and (5) encouraging Federal agencies to undertake research and manpower preparation. In giving its highest priority to this recommendation, the Task Force concluded; "In our judgment these responsibilities warrant Cabinet level status for this Office." [18]

B. Strengthening the Older Americans Act

Stressing that the problems caused by advancing age are being intensified by limited research and trained personnel, the report placed strong emphasis on bolstering funding for Titles IV and V (Research and Training) of the Older Americans Act. These problems, said the Task Force:

> ... are aggravated by insufficient Federal requests for funds by the Executive Branch, small appropriations by the Congress, and unwillingness on the part of Federal grant administrators to devote a greater share of available resources for the support of basic and applied aging research and the preparation of manpower for work with the elderly.[19]

To help provide the commitment needed for this undertaking, the report recommended that additional funds be made available for Titles IV and V for a comprehensive seven point program: (1) Furtherance of curricula on aging in undergraduate and professional schools; (2) short-term training for professionals, paraprofessionals and volunteers; (3) new career programs for middle-aged and older persons; (4) basic and applied gerontological research; (5) research-training centers in aging; (6) dissemination of research findings; and (7) expansion of opportunities for graduate education in the field of aging.

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON AOA

One of the crucial issues considered at the White House Conference on Aging 10 years ago was:

What kind of Federal agency should be established to administer programs for the elderly while serving as a symbol of national concern about the well-being of aged and aging Americans?

With the establishment of the U.S. Administration on Aging in 1965, the question was not resolved. In fact, questions about the role and capabilities of the AoA have intensified in recent years. Those questions should be dealt with at the 1971 White House Conference and in all appropriate preliminary activities.

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[18] Report cited in footnote 4, p. 13.
[19] Report cited in footnote 4, p. 52.

I. RECOMMENDATIONS IN 1961

Even before the first White House Conference on Aging, the Senate Subcommittee on Problems of the Aged and the Aging—the predecessor to the Special Committee on Aging—recognized the need for a central agency to administer and coordinate programs relating to the elderly. At the Conference the delegates directed considerable attention to this issue, but did not recommend what specific form this agency should take. They did, however, recommend that a Federal coordinating agency should be given: (1) A statutory basis and more independent leadership; (2) adequate funds for coordination and other assigned functions through a "line item" appropriation; (3) power to recommend legislative proposals; and (4) authority for seeking coordination among various governmental programs and agencies working in behalf of the elderly.[20]

In that same year, Senator Pat McNamara, the first Chairman of the Committee on Aging introduced a proposal [21] to establish an Office on Aging in HEW, headed by an Assistant Secretary. Departing from this approach, Congressman John Fogarty and Senator Pat McNamara later introduced legislation [22] calling for the creation of a permanent and independent three-man Commission on Aging, appointed by the President. This Commission would have been concerned with the full range of problems for the elderly and would have served as a central focus for developing national policy and providing information, guidelines and support to governmental and nongovernmental agencies with aging programs. Additionally, the Fogarty-McNamara approach would have authorized Federal funding for planning and project grants to help States develop aging programs and for administrative costs of a State's planning and coordinating agency. This measure had the wholehearted endorsement of leading authorities in the field of aging, as well as from senior citizen organizations. In addition, strong support was expressed in this Committee's 1963 report for this independent commission concept "because it would lend (1) better and greater status, (2) balance, (3) strength, (4) continuity, and (5) visibility to Federal activities in aging." [23] The report also stressed that an independent high level agency was necessary because it "can command the wholehearted cooperation of all governmental agencies and of nongovernmental organizations in achieving effective and coordinated action." [24]

II. THE RECORD SINCE 1961

Passage of the Older Americans Act in 1965 represented a compromise for establishing a Federal agency on aging to serve as a central focus for improving and enriching the lives of the elderly.

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[20] The 1961 White House Conference on Aging, Basic Policy Statements and Recommendations. Prepared for the Special Committee on Aging, May 15, 1961, p. 165.

[21] S. 1359, 87th Cong., 1st Sess. Other cosponsors of the bill included Senators Clark (Pa.) and Randolph (W. Va.).

[22] Congressman Fogarty introduced H.R. 10014 on Jan. 31, 1962. A companion bill, S. 2779, was introduced on the same date by Senators McNamara, Long (Mo.), Randolph (W. Va.) and Pell (R.I.).

[23] "Developments in Aging 1959 to 1963." A Report of the U.S. Senate Special Committee on Aging. Feb. 11, 1963, pp. 168–69.

[24] Report cited in footnote 23, p. 163.

However, the legislative history provided clear and convincing evidence that Congress intended AoA to be a strong force for older Americans. Of special significance, the new agency was to be headed by a commissioner—appointed by the President—with direct access to the Secretary of HEW.

But a sweeping reorganization in 1967 of rehabilitation, social and welfare programs led to the creation of the Social and Rehabilitation Service in HEW. Under the new realignment AoA became one of five major units within SRS.[25] In addition, the Commissioner on Aging was to report to the Administrator of SRS, instead of having a direct line of communication with the Secretary of HEW. Complaints were raised on five major fronts:

—AoA might become submerged in welfare oriented programs administered by SRS.
—The reorganization undermined the intent of Congress for a strong, independent agency.
—The new status would reduce the visibility and effectiveness of AoA for leadership on issues relating to the elderly.
—AoA would find it much more difficult, in its new role, to provide coordination of Federal aging programs.
—And the realignment had been achieved without any prior substantive discussions with leaders in the field of aging.

And recent reorganization moves in 1970—to decentralize the training and Foster Grandparent programs to the SRS regions—have raised additional concern over the possibility of downgrading AoA.[26]

III. ISSUES IN 1971

A little more than a year from now—on June 30, 1972—is the deadline for Congress to act on legislative proposals to renew, modify or replace the Older Americans Act. During this time important questions must be analyzed with far-reaching implications for AoA, and the White House Conference on Aging can be an important vehicle for discussing these vital issues:

—Should AoA continue as a unit within SRS? Should it be elevated in stature with a direct line of authority to the Secretary of HEW?
—Should AoA be replaced by an independent Office or Commission on Aging? Or should an Office on Aging be created within the Executive Office of the President, as recommended by the President's Task Force on Aging?

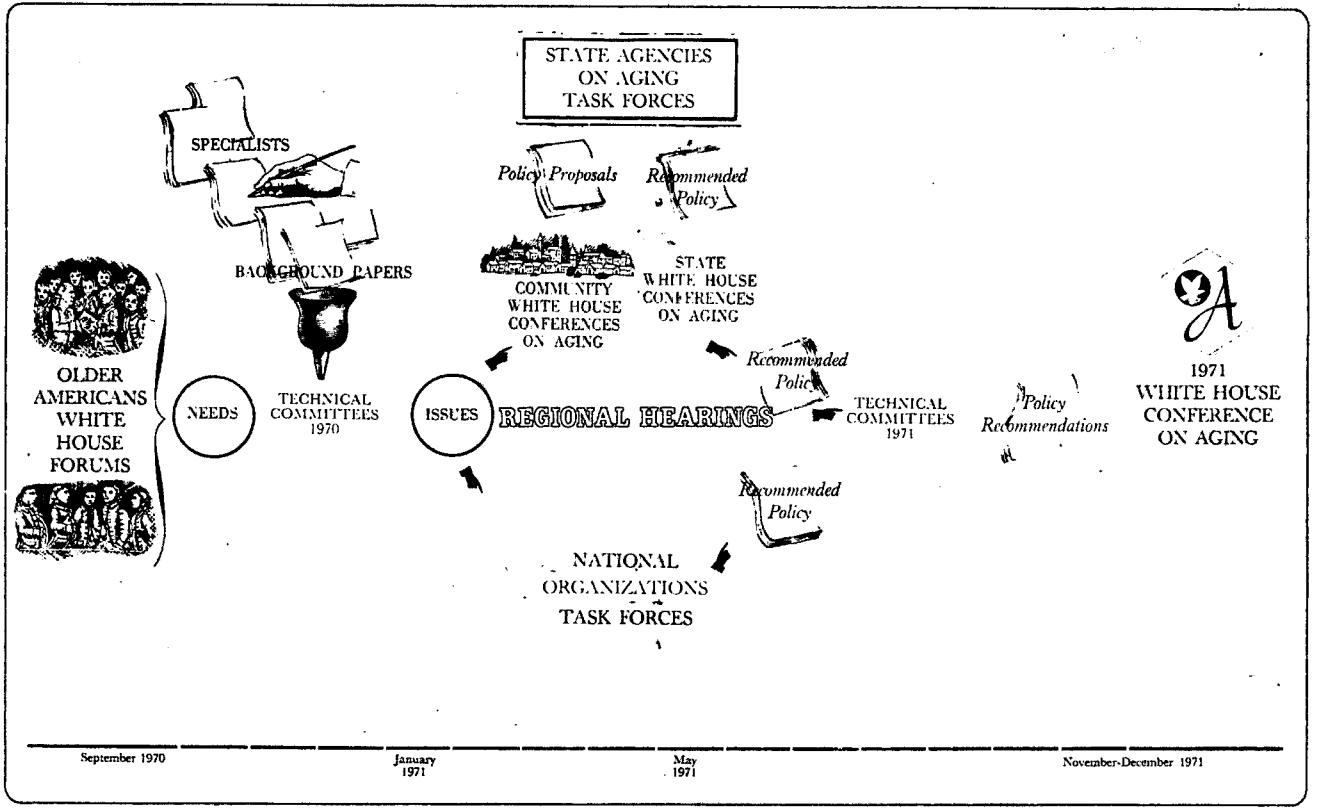
These questions represent only a few of the crucial issues which will require careful consideration during the year of the White House Conference on Aging. Other alternatives must also be weighed and given appropriate attention.

[25] Today AoA is one of seven units within SRS: the other components are Rehabilitation Services Administration, Medical Services Administration, Community Service Administration, Office of Cuban Refugees, Youth Development and Delinquency Prevention Administration, and Assistance Payments Administration.
[26] For further discussion, see p. 129.

Existing policy to deal with the broad range of problems and goals of older Americans continues to be fragmented and haphazard. A clearcut line of responsibility for coordinating Federal activities and priorities is also lacking. Moreover, recent program realignments raise serious questions about the future role for AoA to serve as the focal point on aging.

This Committee recommends that thorough consideration be given, before and during the 1971 White House Conference on Aging, to constructive proposals to enable AoA to fulfill the vital responsibilities assigned to it by law. It is further recommended that administration proposals for renewing the Older Americans Act, changing it, or developing an entirely new approach be submitted at least 1 year before the renewal date of the act (June 30, 1972)—to allow delegates at the White House Conference, experts in the field of aging, and lawmakers to have ample time to consider all related issues.

(Flow Chart, p. 140, supplied by the Administration on Aging.)


STATE AGENCIES ON AGING TASK FORCES
SPECIALISTS
BACKGROUND PAPERS
Policy Proposals
Recommended Policy
COMMUNITY WHITE HOUSE CONFERENCES ON AGING
STATE WHITE HOUSE CONFERENCES ON AGING
OLDER AMERICANS WHITE HOUSE FORUMS
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1971 WHITE HOUSE CONFERENCE ON AGING
Recommended Policy
NATIONAL ORGANIZATIONS TASK FORCES
September 1970
January 1971
May 1971
November-December 1971

CHAPTER XII

RETIREMENT AND FULFILLMENT

"Someone asked me the other day in Washington: 'Why a White House Conference on Aging in 1971—didn't you have one in 1961.' * * * Well, there is 10 years difference and not 10 ordinary years. They are years in which we have reached the conclusion in this country that we don't have to accept things as they are for our older people. We have realized that it will be possible to have the last third of life as satisfying as the first two-thirds."

—John B. Martin, U.S. Commissioner on Aging, August 12, 1970. at 24th Annual University of Michigan Conference on Aging, Ann Arbor.

"In essence, the Task Force is recommending a program to expand the range of choices open to older persons in the belief that human beings should be able to live with purpose and dignity throughout their entire life span. In the American scheme, purpose and dignity should include the possibility of choices."

—President's Task Force on Aging, April 1970[1]

America is a young Nation, but it is also an "aging" Nation. Since the turn of the century the number of persons 65 and older has increased by nearly sevenfold, from 3 million in 1900 to 20 million today. Never before in our history have there been so many older Americans. And each year 1.4 million individuals reach age 65.

In addition, there are 30 million more aged 50 to 64, who will be, in the words of U.S. Commissioner on Aging, John Martin, the "older Americans of tomorrow." These two age groups now comprise about a quarter of our total population.

In terms of sheer numbers, then, retirement—or the prospect of retirement—should be regarded as a major social force in the United States today.

I. A "RETIREMENT REVOLUTION" IN THE MAKING

Four years ago this Committee, in its annual report, described older Americans as a "'pioneer generation' in a largely unrecognized 'retirement revolution' of such magnitude and significance that it

[1] "Toward a Brighter Future for the Elderly, The Report of the President's Task Force on Aging, April 1970", p. 1.

deserves national attention and probably new directions in national policy." [2] This phenomenon will become more and more apparent during the next decade as today's workers become tomorrow's retirees.

A. Longer Periods of Retirement

A person born at the turn of the century had a life expectancy of 47 years. Today the life expectancy at birth has grown to 70 years. Persons now reaching age 65 can expect to live an additional 15 years. [3] With rapid advances in medical science in the decades ahead, it would not be unreasonable for the life expectancy to reach 80 years or beyond by the year 2000. And with the worklife patterns shortening for most individuals, their period of retirement can be expected to increase.

B. Will Tomorrow's Retiree Be Different?

This growth will also probably be accompanied by marked changes in the expectations that Americans bring into retirement with them. Many witnesses have told the Senate Committee on Aging that tomorrow's retiree will have more education (almost half of today's 65+ population never completed elementary school); better health (even now, 81 percent of retirees get along well on their own); the expectation of income higher than today's averages, less of this income from earnings and more from public and private pensions; and probably more power at the polls (so-called "Senior Power" is on the increase; In the 1970 elections 57 percent of the older people voted, accounting for 17 percent of all votes cast.) [4]

II. LOOKING TOWARD THE FUTURE

Four years ago this Committee also undertook a study to explore the vast social and economic changes that can be expected for older Americans during the next three decades. [5] Premised on the assumptions that (1) present trends would continue at a relatively even pace and (2) no major catastrophes would occur, Professor Robert Morris, of Brandeis University, made these observations for the year 2000: [6]

1. The U.S. population will be about 310 million, and approximately 30 million Americans will be 65 and older. Nearly two-thirds of this total, or 20 million individuals, will be 75 and older.
2. About 16 million persons in the 65-plus age category will be single—either widowed, divorced, or never married.
3. Women can expect to live to age 80 on the average.
4. The ratio of surviving males to females is expected to drop further from 76.9 in 1965 to 73 by 2000.
5. Average age for retirement may be reduced to 60.
6. For the average American, about 20 years—or one-fourth of his life—will become "free time" detached from goods-producing labor.

[2] "Developments in Aging: 1967," p. 111.
[3] Excerpted from "Every Tenth American" of this report, p. XIX.
[4] See footnote 3.
[5] Hearing of the U.S. Senate Special Committee on Aging "Long Range Program and Research Needs in Aging and Related Fields," Washington, D.C., Dec. 5 and 6, 1967.
[6] Hearing cited in footnote 5, pp. 30–31.

III. A TIME FOR FULFILLMENT

In previous chapters the Committee has emphasized the economic consequences of retirement. But equally important is the psychological impact of retirement—as well as the recognition that the later years of life can also be a time of fulfillment.

A. Education For and During Retirement

Increasingly, education is being regarded as a lifelong process, not only as a means for preparing people for occupations in a dynamic economy but also as a means of personal enrichment as we move toward a more leisure society. In discussing the importance of education for all age groups, Commissioner on Aging John Martin gave this assessment:

> Education is viewed by the American public as a main artery to progress and a better life for all. We want preschool education for the very young. We want post-graduate courses and night school classes to keep our working population up-to-date on the knowledge and skills of their professions and trades. But, strangely, education for the elderly or even education to prepare people to become elderly has a rather low priority.[7]

Later, the Commissioner added:

> Basically our problem of education for the elderly seems to me to be that we haven't really tried hard enough to reach them. We haven't tried hard enough to offer readily accessible programs with content that they will find stimulating and relevant.[8]

And then the Commissioner outlined some important issues for consideration by the Technical Committee on Education:[9]

—What should be the goals of education for an aging population: To prepare them to make adjustments for retirement, to help them develop new roles or a new way of living or others?
—Should our resources be used primarily to expanding existing programs or to research and demonstration with a view to producing new and improved programs?
—Should education for aging focus on helping people cope with their individual problems? Or should its emphasis be on increasing the elderly's ability to participate in society?

EDUCATION FOR RETIREMENT

Despite a lengthening period of retirement, most individuals are unprepared for this major adjustment in their lives. In our work-oriented society, large numbers are uneasy about the "shock of retirement" or the "threat of leisure." Unless far-reaching policy changes

[7] Statement by Hon. John B. Martin, Special Assistant to the President for the Aging, and Director of the 1971 White House Conference on Aging, delivered to the Technical Committee on Education, 1 of 14 Technical Committees of the Conference, at its first meeting in Washington, D.C., Dec. 17, 1970, p. 1.
[8] Statement cited in footnote 7, p. 3.
[9] Statement cited in footnote 7, pp. 3–4.

are made, retirement and the preparation for retirement will continue to be one of life's most difficult adjustments for the older Americans of tomorrow.

In recognition of this, Senator Walter Mondale introduced the Federal Employees Preretirement Assistance Act, S. 2554, during the 91st Congress.[10] The bill would provide for a comprehensive program of preretirement counseling and assistance for all Federal employees who are eligible for or approaching retirement. Additionally, the bill would require the Civil Service Commission to establish standards for this program; provide training for agency retirement advisers; and study and publish guidelines about related worklife programs, such as phased retirement, trial retirement, and new kinds of part-time work and sabbaticals.

The Committee recommends that a Federal Employees Preretirement Assistance Act be enacted promptly. For Federal employees, this could represent a significant step forward in making crucial adjustments necessary for retirement. In addition, the Federal Government, as a model employer, could provide the impetus for other employers to institute such helpful practices for their employees.

EDUCATION DURING RETIREMENT

As our workweek and worklife patterns change, our concepts about work and education are also changing. Our traditional life cycle of education, work, then retirement is also undergoing changes. Quite frequently, work is interrupted for further training or education, and then back to work again—in the same job or perhaps a new occupation. And our concept about education in the later years is undergoing reevaluation. For many older Americans, education during retirement can be a most rewarding time in terms of acquiring new knowledge about a changing society or finding new ways to use leisure hours.

Increasingly, America is also becoming more leisure-oriented, as our shorter workweek frees workers for more time with their families and recreational pursuits. Since the beginning of the century, the total work hours per year has dropped sharply from about 3,000 to around 2,000 today.[11] And this trend is expected to continue in the future. But this trend also poses a number of far-reaching questions not only for today's workers but also tomorrow's retirees as well as today's retirees;

—How can today's workers better use their free time? Will it be a time of further enjoyment or may it lead to boredom and frustration?

—Assuming today's workers make this adjustment in a satisfactory fashion, will they be better prepared when they retire and have additional hours of leisure?

—Since today's retirees are spending a longer period in retirement, should not our Nation be devoting more attention to the purposeful use of those leisure hours?

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[10] Cosponsors of S. 2554 included Senators Harrison Williams, Jennings Randolph, Frank Church, and Winston Prouty. The bill was introduced July 7, 1969.

[11] Testimony by Max Kaplan, M.D., Research Psychiatrist, Drake University, hearing by the Subcommittee on Retirement and the Individual, of the U.S. Senate Special Committee on Aging, "The Federal Role in Encouraging Preretirement Counseling and New Work Lifetime Patterns," Washington, D.C., July 25, 1969, p. 58.

In addition, we should be preparing for the retiree of the future because he will differ in many respects from the retiree of today. For example, it is predicted that he will have a much higher level of educational attainment. One eminent sociologist, discussing the impact and nature of this trend, gave this estimate of the situation to the Committee on Aging:

> It is important in looking toward the future that we recognize that the educational backgrounds of older persons of tomorrow will be very different than those of today. The relationship of education to occupational roles and status, earning, social status, communications, understanding, tastes, pursuits, attitudes, and so forth, cannot be understated.
>
> * * * * *
>
> It is evident that the next generation of the aged will bring more to his later years than a restricted occupational view of life through a broader educational background. At the same time, as the level of education will increase, it would appear that a national policy of lowering the age for retirement is evolving. It may be that 60 years of age will represent "normal" retirement within the decade.
>
> *The critical issue which must be raised is that of the meaningful use of time for those who will spend anywhere from one-fifth to one-third of their lifespan in retirement.* Persons, in my judgment, will be better prepared for the uses of time if society provides opportunities beyond that of work and economic productivity. [Emphasis added.] [12]

As the length of the period of retirement grows and the level of educational attainment increases for the older Americans of tomorrow, much greater attention should be given to continuing education in the later years. The Committee recommends the enactment of a comprehensive Adult Education Act [13]—not only to help enrich the later years with new opportunities for increasing one's knowledge but also to provide more information for leisure opportunities for persons now retired.

B. Opportunities for New Careers

In far too many instances today, old age is a time of emptiness, when it could be a time of fulfillment or continued self-development. But when a person retires, he need not retire from life. His skills and talents do not suddenly end when he leaves his job. For many of these individuals, advancing years can also mean an opportunity for a new career. It can also be a time of acquiring new skills or putting leisure hours to more productive use.

For many Americans, the most satisfying experiences in their lives are those spent helping their fellow man. And older Americans provide a readymade talent for providing these services to persons in their localities, whether in the form of volunteer activities or part-time community service employment.

[12] Testimony of Walter M. Beattie, Jr., Dean of the School of Social Work, Syracuse University, hearing cited in footnote 5, p. 99.

[13] The Adult Education Association of the U.S.A. points out that at least 476 different Federal programs have adult education components, "yet nowhere is information available about all of them; sharing of ideas and experiences are usually accidental."

The Committee strongly urges that increased attention be given to expanding volunteer activities for retired persons—such as "SCORE" [14] or "RSVP" [15]—and opportunities for community service employment for older persons who need to work to supplement their retirement income.[16]

WHITE HOUSE CONFERENCE OF 1971: THE CHALLENGE ON RETIREMENT

Ten years ago, one of the greatest challenges facing an aging population was: How can extended periods of free time in later maturity be put to more effective use and a more rewarding life. The Conferees then recognized that recreation is a basic human need. Together with work, education, family, and religion, it comprises the full life.

They also emphasized that more effective use should be made of older Americans in the continuing life of their communities—in voluntary activities and other citizenship participation.

And they recognized the clear need for preparation for retirement. With this in mind, the delegates declared:

> **The enjoyment of the later years depends on one's preparation earlier in life so that retirement will not come as a shock but as the culmination of the lifespan with its own rewards—not as the termination of usefulness but as the continuation or as the beginning of a new usefulness characterized by maturity and fulfillment.[17]**

I. RECOMMENDATIONS IN 1961

To help fulfill these goals, the Conferees recommended a comprehensive program calling upon the joint efforts of Federal, State and local governments and the private sector.

Among the major proposals:

—Comprehensive preretirement counseling should be initiated, and it should give emphasis to the triad of concern: (1) time, (2) money, and (3) health.

—Educational programs should be established in schools, labor unions, businesses, churches, and other institutions regarding the meaningful use of free time.

—Opportunities for recreation, voluntary service and citizenship should be expanded.

—Existing public and private facilities should be made more available for the leisure activities of the aged and, where necessary and practicable, these facilities should be adapted for the special needs of the elderly.

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[14] Service Corps of Retired Executives.

[15] Retired Senior Volunteer Program. For further discussion, see p. 133, Chapter XI of this report.

[16] For recommendations regarding volunteer activities, see p. 133, Chapter XI of this report. For recommendations with regard to community service employment opportunities for older Americans, see p. 101, Chapter VIII of this report.

[17] "The 1961 White House Conference on Aging: Basic Policy Statements and Recommendations," prepared for the U.S. Senate Special Committee on Aging, May 15, 1961, p. 116.

—Proper provision should be made for cooperative planning and coordination of services at all levels of government.

II. THE RECORD SINCE 1961

Today a number of volunteer programs—such as the Retired Senior Volunteer Program and the Service Corps Of Retired Executives—have been established to provide new opportunities for service for older Americans. Pilot projects for preretirement counseling, sabbaticals, trial retirement, phased retirement, and other innovations have been undertaken by the Federal Government, but on a limited basis. Senior citizen centers have been established around the country. And thousands of older Americans have participated in the recreational activities funded by AoA.

III. ISSUES IN 1971

But since so little is yet known about leisure, recreation, and the impact of a lengthening retirement period, it will be essential for the delegates at the 1971 Conference to develop a body of knowledge upon which intelligent policy decisions can be made. In the words of Elias Cohen, the 1971 White House Conference on Aging represents an entirely "different ballgame" [18] than the last one. Movement must come from the Conference, but Cohen also notes:

> The issue this time out is *not* publicizing the plight of the elderly. * * * The issues involve the mobilization of facts rather than opinion and desire * * * *The issue is to produce means of intervention that will be adequate to the task.* (Emphasis added.) [19]

And with regard to the changing life patterns in retirement, Cohen said:

> Research on the impact of retirement might well influence national retirement policies. The impact of retirement on the labor force and the rest of society may be equally important, especially as we witness a growing gap between the aged and the young, often manifest on school bond issue votes, and pressures for tax exemptions and exonerations for the aged. Donald Kent, former Director of the DHEW Office on Aging asks: "What is the impact of the aged population on the rest of the population?" He points out that between now and the end of the century 65 million people will celebrate their 60th birthday, and 20 million will grow from early old age to advanced old age (Kent, 1965).[20]

Earlier in the chapter, the Committee took a look into the future—to the year 2000—to project what retirement patterns and life would be like at that time. Today less than 30 years remain

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[18] Aging and Human Development. Vol. 1, No. 1, Wayne State University. "The White House Conference on Aging: Will It Fail?" by Elias S. Cohen, Commissioner, Office of Family Services, Pennsylvania Department of Public Welfare, p. 55.
[19] Article cited in footnote 18, p. 55.
[20] Article cited in footnote 18, p. 56.

for adjusting to these far-reaching changes in retirement and for the future older American. Thus, the activities of the 1971 Conference take on a double meaning—not only for the retiree of today, but also because the activities in 1971, as well as the policies formed during the decade of the 70's, will take us one-third of the way to a substantially different retirement life for the aged at the turn of the century.

MINORITY VIEWS

MINORITY VIEWS OF MESSRS. PROUTY, FONG, MILLER, HANSEN, FANNIN, GURNEY, SAXBE, BROOKE, AND PERCY

INTRODUCTION

"Toward a national policy on aging" is the theme of the second White House Conference on Aging called by President Nixon and scheduled for November 29 through December 4 in this year of 1971.

This is the first massive effort on a nationwide scale to appraise the needs of older Americans since the White House Conference on Aging 10 years ago at the end of the Eisenhower administration.

It is timely to assess the degree of progress that has been made during those 10 years and to look at steps taken so far to make the 1971 conference responsive to President Nixon's charge that it "develop a more adequate national policy for older Americans."

The 1961 Conference on Aging was preceded by numerous community and statewide meetings involving leadership from all walks of life. Through them and the sessions in Washington, attention was focused on the 20th century revolution in aging wrought by scientific progress and rising living standards.

The 20th century revolution in aging has brought sharp increases in the number of persons past 60, 70 and 80, and has heightened individual capacities for personal activity in even the latest years of life.

As a result, the Nation has been faced with new problems and challenges.

The Eisenhower conference made clear that attitudes toward aging and policies affecting older persons which may have been adequate for the past, should be replaced with new concepts appropriate to the growing needs of millions of older Americans for independence and continued involvement in the mainstream of national, community and family life.

If nothing else, the 1971 White House Conference should bring to the Nation's attention a better understanding of where it has succeeded and where it has failed in meeting these challenges since the Eisenhower administration.

More importantly, it is to be hoped that from the conference will come useful guidelines for more adequate responses to the hopes, fears, aspirations and needs of the aging. The Nixon administration's determination that older persons themselves will be heard encourages us in this hope.

Over 500,000 individuals from all over the country already have said what they think through more than 6,000 community forums of older Americans held during September.

These forums, made possible through cooperative efforts of the White House Conference staff, State commissions on aging, community agencies, organizations of older people, and other groups, constituted a new idea in White House Conference technique. Summaries of opinions expressed should be valuable at community, State and national levels.

President Nixon will ask the States to follow through on this idea of broad representation from older Americans as official delegates to the conference are selected.

There obviously should be delegates who will provide a cross-section of views from urban, suburban and rural communities, from minority groups, and from various social and economic levels.

Important as the 1971 White House Conference on Aging will be in further pinpointing needs of older Americans, we do not have to await its results to evaluate much of what has happened in the 10 years since the 1961 conference.

Incomes have increased through improvements in Social Security, some reform in private pension plans, and generally stronger income from savings. Highly significant have been Social Security increases totaling 26.5 percent which were enacted by Congress and approved by President Nixon during the past 15 months.

A majority of persons past 65 appear now to have incomes sufficient to provide them with a decent standard of living. The fact remains that there are still several million older Americans who are hard pressed by incomes marginally adequate or totally inadequate.

Both the poor and the comfortably situated elderly have been victimized by persistent inflation during the past 10 years. There is little question that uncontrolled deficit spending by Democratic-controlled Congresses during those years has been a major factor in causing this hardship.

High priority should be given to adoption of an Older Americans Income Assurance Plan which will guarantee that our national commitment to decent standards of living with dignity becomes a reality for all the aging. Further improvements in Social Security, Railroad Retirement, private pensions and other retirement programs are still needed to meet this commitment.

Delivery of medical care has improved, but serious deficiencies still exist in the quality and scope of services. Especially noteworthy has been the failure to meet the need for long-term care of the aged sick and infirm at a price within their reach.

Homeownership among persons past 65 is high, and progress has been made in housing programs for the elderly. Nonetheless critical unmet housing needs are still to be found in rural communities and the inner city of metropolitan areas, especially among those who have no living spouse.

Some "second career" and volunteer services opportunities have developed, including programs such as Green Thumb and Foster Grandparents which offer important income supplement as well as service

to the community. Yet many older Americans still find time hanging heavy on their hands, with no opportunity for challenging activities commensurate with their abilities and desires.

Senior centers and other projects offering worthwhile companionship, recreation, and educational opportunities have been started in many communities, but there are many communities without them.

A call for more flexible retirement policies was clearly voiced by the Eisenhower White House Conference on Aging. There still is too little recognition, however, that 19th century arbitrary, compulsory retirement policies are unsuited to the needs of individuals and the Nation in the latter part of the 20th century.

On the contrary, there seems to be a national fixation on earlier and earlier retirement. The void thus created in the lives of many older persons poses a threat to both meaningful living and national productivity.

Too little has been done to meet the problems of retirement through part-time jobs, economically practical volunteer activities, or modifications in national concepts of what the later years of life should offer.

If medical and biological scientists are correct in predictions that average life expectancy in America will soon rise to 90, 100, or more years, it is evident that the problem of retirement will become even more serious unless there is positive action by all sectors of society to develop new policies and programs.

While retirement policies have important social, psychological and health implications for many, they are also inextricably intertwined with income problems. The need for achievement and maintenance of decent incomes is still, as it was 10 years ago, the number one problem facing older Americans.

Summary of Recommendations

We urge all elements of American society to unite in a comprehensive effort to open new doors for participation in the mainstream of national, community and personal life by older Americans.

Both public and private sectors, nonprofit and profit oriented alike, should face up to the challenges created by the 20th century revolution in life patterns among persons past 65.

The goal should be reinforcement and strengthening of attitudes, opportunities and programs which recognize that past responses to the problems of aging often are inadequate to needs older Americans have today and may have in the future.

Elsewhere in this report of the Special Committee on Aging, there is enumeration of a multiplicity of factors relating to needs of older persons. They, and the voluminous statistical data accompanying them, deserve comprehensive evaluation and appropriate action.

Recognizing the intense competition for funds and skilled personnel in and out of government, we believe it is also important to make judgments on priorities related to the most pressing needs of older Americans.

We recommend prompt action on the following 30 specifics as part of the Nation's effort to strengthen responses to needs of older persons.

Most importantly, we recommend immediate steps to assure achievement and maintenance of decent incomes for all older Americans through:

1. Congressional enactment of an Older Americans Income Assurance Act which will provide economic support sufficient to assure that all of the elderly enjoy a decent standard of living;
2. Control of inflation—the most universal problem of retirees—through changes in congressional policies reflected in record votes against waste, extravagance, and nonessential Federal spending, which are major factors in rising living costs;
3. Vigorous efforts to expand and improve the Nation's unique private pension system;
4. Expansion of job opportunities, full-time and part-time, for older persons desiring employment.

We recommend correction of inequities in Social Security beyond the recent 10 percent benefit increase, and in other Federal programs providing income for older Americans, including:

1. Automatic cost-of-living increases in Old Age, Survivors and Disability Insurance benefits (OASDI) under Social Security and in Railroad Retirement benefits;
2. Payment of 100 percent of primary OASDI benefits to aged widows instead of the present 82½ percent of amounts payable to surviving covered workers;
3. Upward adjustments, actuarily determined, in OASDI benefits for those who defer retirement beyond 65, so that their continuation in the work force will not be penalized;
4. Upward adjustments in OASDI benefits for married couples both of whom work and thus pay dual Social Security taxes without receiving higher payments when they became OASDI beneficiaries;
5. Extension of OASDI, financed from the general fund of the Treasury, to more people not covered by an adequate retirement program;
6. Further liberalization of the OASDI earnings test to permit Social Security beneficiaries to earn more money without penalty;
7. Increases in Railroad Retirement benefits commensurate with recent Social Security increases, and
8. Revisions in the veterans pension program to protect the right of veterans to a fair share of higher income levels among older Americans.

We recommend improvements in medical care for the aging and its financing through:

1. Removal of the present requirement that a Medicare beneficiary must necessarily have 3 days of prior hospitalization to be eligible for extended care;

2. Reexamination of coinsurance and deductible features of Medicare to determine how best liabilities they impose on beneficiaries may be lightened without injury to the program's financial integrity;

3. Elimination of retroactive denials of extended care facility and home health agency benefits under Medicare;

4. Prompt consideration of how best to relieve older people of excessive burdens imposed by costs of medical appliances, drugs, and needed professional services not now covered under medicare;

5. Provision of an unlimited long-term institutional medical care benefit for all persons over a specified advanced age, such as 80 years, and

6. Broadening eligibility standards for admission to Intermediate Care Facilities by transferring this program of care and services from Title XI of the Social Security Act, which limits recipients to persons on welfare rolls, to the Medicaid program under Title XIX, with its broader eligibility standards.

We recommend more adequate elderly housing projects and programs based on:

1. Strengthening of Federal support for private elderly housing under both mortgage insurance and direct loan programs;

2. Improvement of public housing programs to make them more responsive to special needs of older persons.

We recommend tax relief measures, as a key to independence among older persons, including:

1. Updating of the retirement income tax credit provisions of the Internal Revenue Code;

2. Restoration of full deductibility for medical and drug expenses, subject to a reasonable ceiling, from older persons' incomes subject to Federal taxation, as provided prior to 1967.

3. More liberal tax incentives for persons making substantial contributions to the support of needy elderly relatives, and

4. Encouragement of appropriate tax relief measures for older persons at State and local government levels.

We recommend more intensive and broadened research on the nature of the aging process, and socio-economic implications for the future, through:

1. Adequate financing for research in the field of aging;

2. Creation of a mechanism for continuing in-depth study of economic, physiological, psychological and social factors in aging as a basis for evaluating policies and programs affecting older Americans of the present and the future.

We recommend improvements in special services, programs and activities designed to broaden individual horizons of older Americans, including:

1. Expansion of economically feasible "second career" and volunteer service opportunities for continued involvement of retirees in the mainstream of community life;

2. Development of transportation services with particular reference to special needs of older persons;

3. Better funding of State commissions on aging with special emphasis on community level programs such as senior centers, homemakers, meals on wheels and friendly visitor services, and educational, social and recreational activities designed to combat the twin fears of aging—loneliness and frustration; and

4. Upgrading of the Administration on Aging and strengthening of its ability to serve as a focal point for coordination of Federal activities and programs on behalf of older Americans.

Decent Incomes for All Americans

Achievement and maintenance of incomes adequate to provide decent standards of living remain, as they were 10 years ago, the number one problems of older Americans.

Improvements in private pension plans, Social Security, Railroad Retirement and other Federal Government pension programs have combined to raise income levels among retirees during the decade. Most recent have been two Social Security increases totalling 26.5 percent enacted by Congress and approved by President Nixon during the past 15 months.

Obviously prompt attention must also be given by Congress to updating the Railroad Retirement program and the Veterans Administration pension program so as to be sure that their beneficiaries will receive comparable treatment, and, in the case of veterans will be protected against loss of pension benefits by reason of the Social Security raise. We recommend early action for these purposes.

Despite advances which have been made, there still remain several million persons past 65 whose incomes are inadequate to provide the barest necessities of life with dignity. As documented elsewhere in this report, there are many others whose incomes are so close to the poverty level that the slightest economic setback will subject them to serious hardship and who can enjoy the smallest luxuries of life only at the sacrifice of necessities.

Nothing related to older Americans deserves higher priority than a concerted national effort to give all persons full opportunity for decent standards of living during the later years of their lives.

Because we regard it as a minimum necessity, we urge that Congress give most careful consideration now to development of an Older Americans Income Assurance Program, outside the welfare pattern, which will assure at least minimum income, through governmental supplements, to all the elderly who would otherwise not be able to achieve decent standards of living.

One such proposal was offered in the 90th Congress and, with modifications, again in the 91st and 92d Congress by Senator Prouty of Vermont. Senator Prouty's bill, S. 1385, provides that there be a Federal supplement to bring the total income of each unmarried person over 65 up to $1,800 a year and each married couple up to $2,400. The subsidy would amount to the difference between other income of the individual or couple and the $1,800 and $2,400 respectively.

Some plan such as this appears to be the one way that the problem of basic income adequacy can be met at a cost in keeping with the willingness of younger people to pay the bill. Financing out of the general fund spreads the cost more equitably and reduces burdens on those least able to pay.

Another way of approaching income supplements was offered by Senator William B. Saxbe of Ohio when he introduced an amendment to the Administration's proposed Family Assistance Plan which would provide a minimum of $155 a month for persons age 72 and over. Indeed the portions of the President's plan concerned with older persons moves in the direction of such objectives.

A major advantage of a general income supplement program such as the Prouty proposal is that it would serve persons not now covered by Social Security, including many school teachers, State and Federal employees, and others whose employment is not or was not covered in the past by Social Security. Large numbers of these persons are among those with lowest retirement incomes.

As an income supplement program, the cost to the taxpayer would be much lower than would be required through any effort to raise minimum Social Security benefits to comparable levels.

Desirable as it might be to promise older Americans that their basic needs can be met through raising minimum Social Security benefits to $125 or $150 a month or more in the foreseeable future, it is unfair to do so. There is no support for the belief that Congress will take such action. The contrary is indicated by the history of Social Security amendments. The reason such promises are unrealistic, of course, is the cost.

Young workers may be sympathetic to the importance of caring for their elders, but there is evidence that they would be unwilling to pay the increased Social Security taxes necessary to support such minimum benefits. Congressional hesitancy to pass such proposals reflects such resistance by the young.

Many young Americans, struggling to meet immediate family expenses, pay Social Security taxes higher than their Federal income tax liability. At the same time as much as 40 percent of income subject to Federal income taxes is exempt from Social Security taxes. Much of this income is in the hands of persons best able to pay.

An Older Americans Income Assurance Plan, financed through general revenues and offering adequate income supplements, would be responsive to the needs of the aged, yet be attainable at a price tag acceptable to the young.

Such an income supplement plan would have a major advantage as a mechanism to eliminate poverty among the elderly because it would avoid unearned increments to persons, many of them wealthy, who are not in need. This is one reason why the total net cost to the taxpayer would be much lower than for a comparable minimum Social Security benefit. As noted above, this is important for favorable consideration.

Adoption of the Prouty proposal or one similar to it would result in the removal of many if not all of the 2 million persons past 65 from the old age assistance welfare rolls. It would provide help to which these persons are entitled, but with dignity and grace.

Income Stability Important to Retirees

Continuing national policy regarding the economics of aging must go beyond the momentary achievement of income adequacy, either for all retirees or for an individual. There must be a constant effort to pro-

vide maximum assurance that such incomes, once attained, maintain their purchasing power.

Because of the wide variety of resources which older Americans bring to their efforts at income adequacy, the importance of stability in the dollar's value can hardly be overemphasized. Departures from Federal fiscal policies which resist the hidden tax of inflation are justifiable only for brief periods of time and only when the alternatives are more serious economic problems of a different type.

The kind of deficit spending which characterized the period since 1960, however, with no regard for the total economic needs of the Nation, can only produce a situation in which rising living costs are rapid and efforts to bring them under control risk other equally serious consequences.

That millions of older Americans were victimized by the unbridled spending spree of that period cannot be questioned. They suffered losses through the hidden tax of inflation which can probably never be recouped. They were aggravated by the sharp price rises which accompanied an expanding involvement of America in a war in Southeast Asia, with its inevitable inflationary impact.

Success of President Nixon's efforts to extricate the country from the Viet Nam War, clearly reflected in continuing reductions of American personnel engaged in combat and the steady withdrawal of such young men from Viet Nam, can only result in reduction of pressure on the dollar. When this major step forward in American foreign policy has been completed, there will be an inevitable improvement in the dollar's stability.

Older Americans will never be given assurances that their incomes will be adequate to needs, however, unless we abandon the national long-term policy of deficit financing which has characterized Democratic-controlled Congresses in recent years—even when their has been full employment and the economy has been overheated.

There should be a return to a sound fiscal policy with full recognition of the need for elimination of waste and extravagance in the Federal Government and the assignment of spending policies directed at national areas of need which have fully supportable priority.

Improvements in Social Security OASDI Program

There is no question that the Old Age, Survivors and Disability Insurance program under the Social Security Act (OASDI) is now the most important single element in the incomes of older Americans. We believe that it is important to review its effectiveness constantly for the purpose of improving its ability to serve the Nation.

The two increases in OASDI benefits enacted during the past 15 months and approved by President Nixon have been important steps in strengthening the program. Together they have resulted in a badly needed 26.5 percent increase in benefits. We believe that such responsiveness to the needs of older persons is appropriate.

There still remain a number of improvements on which action should be taken without delay. There follows a discussion of some

which we feel deserve high priority from the Congress as it considers additional Social Security amendments during the 92d Congress.

OASDI Automatic Cost-of-Living Increases

A major improvement in OASDI which minority members of the Committee on Aging and the Republican Party have long advocated is provision of an automatic cost-of-living increase in benefits to provide immediate response to rising prices when they occur. President Nixon continues to place a high priority on such an automatic increase provision.

As when first introduced in the Senate by Senator Jack Miller of Iowa some years ago, such benefit escalation would require no increase in Social Security tax rates. It would obviate the game of "catch-up" which has characterized Social Security since its inception, a game in which, until very recently, the beneficiaries have been consistent losers.

Too often past increases have been voted by the Congress only after delay has forced many beneficiaries into inexcusable financial difficulties.

There is clear precedent for automatic cost-of-living increases in other federally supported pension programs. There is no reason why its advantages should not be extended to the mass of older Americans who rely on OASDI so heavily.

We strongly recommend again that Congress act to provide for automatic cost-of-living increases in Old Age, Survivors and Disability Insurance under Social Security and in Railroad Retirement benefits.

We have been gratified at growing bipartisan support for this proposal. With President Nixon's commitment to its adoption and approval from both political parties, which was amply reflected in independent actions last session by both the Senate and the House of Representatives on the Social Security Amendments of 1970, which regretably failed of final passage, we trust that favorable action on this important measure will be taken without delay.

Higher OASDI Benefits for Widows

The current discrimination against widows under the Social Security benefit structure is another matter that deserves prompt congressional attention.

Reports of the Committee on Aging and other sources have repeatedly pointed out that no group among the elderly is subject to more severe hardship than aged widows. One contributing factor has been failure to pay the same OASDI benefits to surviving widows as has been paid to surviving worker husbands. Normally the husbands receive 100 percent of the primary Social Security benefit on the death of their spouse; the widow, however, receives only 82½ percent. There seems to be no excuse for such discrimination.

We recommend payment of 100 percent of primary OASDI benefits to aged widows instead of the present 82½ percent of amounts payable to surviving covered workers.

In so doing, we are reiterating a position taken repeatedly in earlier minority views of this committee. In such statements we have discussed the impropriety of the outmoded concept that the breadwinner, per se, should have preferential treatment. We have also observed that the widow, with an average greater life expectancy than the widower, and thus subject to the hazards of inflation over a longer period of time, may have the greatest need for her OASDI benefits.

Persons Who Defer Retirement

Every Committee on Aging Minority Report has urged that efforts be made to make OASDI retirement benefits under Social Security more flexible so that individual older Americans could best tailor them to their own needs and desires.

One way of accomplishing this would be through permitting persons who defer retirement to an age beyond 65 to receive higher benefits.

The average number of years for which OASDI payments would be made to a group of people retiring at age 70, for example, would be less than for a group retiring at age 65. Equally obvious is the fact that retirees at the later age would have paid Social Security taxes for a longer period.

Recognition is given to the principles inherent in these observations with regard to those who begin to receive benefits before 65. If they so elect, their benefits are reduced accordingly.

We believe such flexibility should work both ways.

We recommend, therefore, upward adjustments, actuarially determined, in OASDI benefits for those who defer retirement beyond 65, so that their continuation in the work force will not be penalized.

Our advocacy of such a concession of higher benefits to the late retiree does not in any way constitute objection to retirement at age 65 for those who want it and many do. We do believe, however, that this option should be available.

The extra contribution to society by those who continue full productivity beyond age 65 can be great. In times of skilled manpower shortages, it may even be crucial to social and economic progress.

There are many persons now past 65 who are making such contributions, some in lofty positions, some in small. Had there been such flexibility in OASDI during years past, there might be many more. They as individuals and the Nation as a whole would have benefited.

Working Couples Under OASDI

We believe that it is important that all inequities in the Social Security system should be eliminated as rapidly as possible. This is reflected in other recommendations made in this and previous minority reports of the Committee on Aging.

One inequity with which we have developed a growing concern is that experienced under OASDI by working couples.

We recommend upward adjustments in OASDI benefits for married couples both of whom work and thus pay dual Social Security taxes without receiving higher payments when they become beneficiaries.

Today it is common practice for both husband and wife to work—and pay Social Security taxes. Such dual taxation sometimes continues throughout life. Sometimes the wife is in the work force until a baby arrives and then resumes employment after the children have grown up.

In most cases, little or no additional retirement benefits are received as a result of this dual contribution.

An example will illustrate the inequity:

> Let us assume one couple (A), in which the husband, on reaching retirement, has average earnings subject to Social Security withholding of $4,000 a year. His wife has had such average earnings of $2,000 a year.
>
> Another couple (B) is one in which only the husband has been employed—with average earnings subject to withholding of $6,000 a year.

The two couples have made virtually identical contributions to the Social Security system, but benefits payable at retirement discriminate sharply against the first couple (A). This is due to the fact that normally their benefits would be calculated only on the husband's income of $4,000.

This problem hardly existed before World War II. Since then, for part or all of her married life, the working wife has become an increasingly important factor in our economy. Already there are many retirees who have suffered from this unequal treatment of working couples. There will be more in the future.

If the Social Security system is to retain its character as a contributory insurance program, this inequity requires early attention.

Extension of OASDI to More People

For a number of years Minority Views of the Special Committee on Aging have recommended extension of OASDI benefits to more people.

We again recommend extension of OASDI on a properly funded basis to more people not covered by an adequate retirement program.

Consideration should be given within the context of this recommendation to use of the general fund of the Treasury as a source of revenue to accomplish this purpose to the extent that added coverage is not otherwise adequately funded.

It seems especially important, even with the high percentage of citizens now covered by OASDI, that extension of it to all people not covered by railroad retirement, civil service or similar adequate retirement systems is a legitimate objective of our national policy on aging.

Liberalization of OASDI Work Test

Another badly needed change in the Old Age, Survivors and Disability Insurance program is that related to limitations on the amount a beneficiary may earn without penalty.

Again we recommend liberalization of the OASDI earnings test so as to permit Social Security beneficiaries to earn more money without penalty.

Repeatedly we have expressed our concern about this impediment to independence of action and both social and economic well-being of older persons. The record is too complete on the undesirability of its retention at the present inadequate level of $1,680 unpenalized earnings to justify laboring the issue here. There must be a realistic increase in the amount a beneficiary may earn and still retain all of his Social Security benefits.

We note approvingly that President Nixon, in pursuit of his desire that ultimately the earnings test will be completely removed from Social Security, has advocated that earnings in excess of the basic unpenalized amount should be subject to a loss of $1 for each $2 earned on an open ended basis instead of the current provision which stipulates that earnings above $2,880 shall be lost entirely.

Medical Care Priorities

No medical care needs are greater than those of the elderly and disabled. It is essential that highest priority be given to elimination of deficiencies which may exist in such care.

The foregoing observation is made because we believe it should not be lost sight of in the debate which appears to be emerging in this Congress on various proposals for national health insurance for all citizens.

In our judgement it is important that care be taken to be sure that the needs of the elderly for medical care be met regardless of what course may be followed for younger people. To the extent that there may be delay in development of a comprehensive program for all, we believe improvements in Medicare and other programs serving the aging should be given consideration first. Beyond this, we believe that if a total national health insurance program is adopted that it be done only with assurance that older persons will get at least equal treatment.

Because of uncertainties in the total health picture, we urge prompt action on several recommendations relating to programs of medical care now serving the elderly.

We recommend removal of the present requirement that a Medicare beneficiary necessarily must have 3 days' prior hospitalization to be eligible for benefits in an extended care facility.

Historically the extended care services were to be restricted to use of such facilities as a continuation of necessary hospitalization and would be used primarily to provide care at a lower cost than would be possible in the hospital. The 3-day prior hospitalization was designed to guarantee that Medicare would not be transformed into a long-term care program.

There is evidence to suggest that the hoped for cost reductions have not equaled expectations. On the contrary, there apparently have been numerous instances in which patients who could have been cared for adequately in a less expensive facility than the hospital have been placed in the hospital instead—solely because of the 3-day requirement.

While it may be necessary to impose limitations as to the precise medical conditions for which admissions to extended care facilities would be permitted under our recommendation, we believe it important that the arbitrary 3-day waiting period be eliminated.

There are many conditions, including those unrelated to so-called long-term care, for which institutional care is needed, but at a level less costly than the hospital. It is time that the Medicare program be changed so that in such cases the judgement of the physician can prevail. We believe that this will be of benefit to both the patient and the taxpayer in the long run.

We recommend provision of an unlimited long-term medical care benefit for all persons over a specified advanced age, such as 80 years.

Previous minority reports of this committee have advocated development of a comprehensive sheltered care program for the elderly. Our current recommendation proposes a major step toward ultimate achievement of this goal. We believe it is high time for action.

The American Association of Homes for the Aged and others have proposed that this long-term care benefit be made a part of Medicare. Whether this route is followed or it is made part of another program is, we feel, of less importance than seeing to it that such care is provided—at least for those in the very latest years of their life and who in consequence have the greatest need.

We recommend thorough reexamination of coinsurance and deductible features of Medicare to determine how best liabilities they impose on beneficiaries may be lightened without injury to the program's financial integrity.

Legitimate use of deductibles and coinsurance in order to reduce costs and avoid program abuse cannot be challenged. Nonetheless there are many persons for whom they now constitute a serious hardship. Some way or other a balance must be achieved so that older patients are adequately served by Medicare and the program's financial integrity is maintained. We believe this is possible and that exploration of how best to do it should begin at once.

We recommend elimination of retroactive denials of extended care and home health benefits under Medicare as promptly as possible.

Deliberations of the Committee on Aging have clearly delineated the serious problems created for patients and providers of service alike through denial of payments for services, especially in extended care facilities and by home health agencies, which have been rendered under the assumption that they would be paid for under the Medicare program. That most of these denials have been in compliance with the existing law, in no way diminishes the problems they have created.

We are aware that this problem has been given consideration by legislative committees of the Congress, but we feel that action as promptly as possible is essential.

We recommend prompt consideration of how best to relieve older people of excessive burdens imposed by costs of medical

appliances, drugs and needed professional services not now covered under Medicare.

It is unnecessary here to recount the numerous ways in which highly valuable appliances, drugs and professional services which are not subject to Medicare reimbursement can impose heavy burdens on older persons. These life-giving elements of medical care and those which may, at equal expense, widen opportunities for life-participation are too important in the total medical and dental armamentarium to be ignored.

We recommend broadening eligibility standards for admission to Intermediate Care Facilities by transferring this program of long-term care from Title XI of the Social Security Act, to the Medicaid program under Title XIX.

Title XI limits its services to persons declared categorically indigent as a prerequisite to receipt of welfare payments. Title XIX, through the State Medicaid programs, provides medical services to low-income beneficiaries as a means of keeping them from becoming indigent. We believe the latter approach is especially desirable for older people who, by the very nature of the services, would be most apt to use them.

The obvious effect of the transfer we propose would be to increase the number of older persons who would become eligible for Intermediate Care Facility benefits. Coupled with our other recommendation for Extend Care Facility benefits to a specified group of most advanced age, it would be a major step toward the sheltered care program which we have so long advocated.

Housing

It is estimated that over two-thirds of American couples over age 65 and a surprisingly high number of older single persons own their own homes. That most of these homes are free of mortgages emphasizes the dedication the current older population brought to their belief that they should save during their working years and make preparations so far as they were able for their retirement years.

While older home owners are due a tribute for their efforts, it would be erroneous to use these statistical data to show that the housing problems of the elderly have been solved. The facts suggest otherwise, even if we disregard the problems which older home owners may have in maintaining their residences in a state of good repair.

Studies made by this committee show that there are many older persons in both rural areas and urban for whom decent housing is simply not now available. The problems in the inner cities have received most widespread attention, but they are no less real in rural communities.

There is no question but that housing is an area in which the productive forces of the private sector can be an important instrument of social policy. This is true for those who are profit-oriented as well as nonprofit institutions such as the various religious bodies who have so long provided leadership in the field of housing for the aged.

We recommend strengthening of Federal support for private elderly housing under both mortgage insurance and direct loan programs.

It is clear that the Federal Housing Authority mortgage insurance program has been important in stimulating construction of housing for the elderly. Those efforts should be continued and improved in the light of expanding needs. There is also an extremely important place for low-interest direct loan assistance as exemplied by the so-called Section 202 program of the Housing Act. Only through strengthening of both of these concepts can we supplement purely individual efforts which presumably will continue as the prime element in housing.

We also recommend improvement of public housing programs to make them more responsive to special needs of older persons.

Unquestionably many older persons will want to avail themselves of public housing and they should be free to do so. It is important in such projects, however, that there be adequate provision—as should be expected also in private group living arrangements—for services which recognize special needs of older persons. This should go beyond living quarter design and encompass opportunities for recreation, social activities and other services essential to full lives.

In addition to the problems faced by those to whom adequate housing is now almost totally unavailable, there are also some serious difficulties even for those who own their own homes. One of the most important of these relates to how they can continue to hold their homes in the face of inflation-inspired rising property taxes.

Tax Relief

We recommend encouragement of appropriate tax relief measures for older persons at State and local government levels.

While the burdens imposed by rising property taxes may be among the least responsive to Congressional action, it is one of the most common forms of tax distress that older persons encounter. As such we believe it deserves Congressional attention.

Whether encouragement of property tax relief should be a part of possible revenue sharing proposals or brought about through other means deserves study. We do feel that this special problem on older Americans should be fully recognized.

There are other avenues of tax relief for older persons, of course, which are directly responsive to Congressional action. There are several which are very important and deserve early action.

We recommend updating of the retirement income tax credit provisions of the Internal Revenue Code.

Early action on this recommendation is important to reestablishment of equitable tax treatment for those whose retirement incomes are derived from sources other than Social Security.

The retirement income credit section of the Internal Revenue Code was enacted in 1954. It established for certain retirees a tax benefit similar to that available to other retirees by means of the tax-free income they receive from Social Security.

The retirement income credit was computed on the basis of the maximum Social Security benefit. By the language of the tax code, however,

the tax base still stands at $1,524 which was the appropriate figure 9 years ago. Since that time, of course, there have been several Social Security increases, but no comparable adjustment in the retirement income credit provision. Congress should act promptly on updating section 37 of the 1954 Internal Revenue Code so as to provide equal tax treatment for all retirement income as nearly as possible.

We recommend restoration of full deductibility for medical and drug expenses, including dental services, subject to a reasonable ceiling, from older persons' incomes subject to Federal taxation—as provided prior to 1967.

Medical services are still a major cost to older persons despite Medicare. Some retirees, of course, are still ineligible for Medicare. For those who are, much of the medical care costs are related to types of service which reduce the burden on Medicare.

For those not subject to Federal income taxes, it may be assumed that such services will be forthcoming from Medicaid programs of the several States. It appears appropriate, therefore, that older Americans who do pay income taxes should have equitable tax relief.

Not all tax relief is a matter of changing the law. One important administrative area where the actual taxes paid by older persons can be reduced is in the tax form itself.

It is evident from information presented to the Committee that many older Americans pay more income tax than they should because of complexities in the tax form and the difficulties in understanding the instructions.

We urge the Internal Revenue Service to continue its review of the income tax forms to make absolutely certain that possible misunderstandings of tax liabilities shall be held to a minimum.

We also recommend adoption of more liberal tax incentives for persons making substantial contributions to the support of needy elderly relatives.

In spite of savings, private pension plans, Social Security, and other private or public mechanisms to provide income for older Americans, there remain a number who require financial help from sons, daughters, or other relatives.

Family responsibility, we believe, should be encouraged. The tax structure offers one way of such encouragement. We also feel that relatives who are willing to assume responsibility for care of needy elderly persons should not be penalized through taxation of income they have voluntarily given up to that purpose.

Among possibilities which should be given consideration for this purpose are proposals which would:

1. Permit taxpayers to claim exemption for dependent relatives over 65 with incomes in excess of $600 when providing more than half of their support;
2. Provide recognition, through tax concessions, to persons who provide necessary assistance to elderly relatives even when this is less than half of the older person's income;
3. Amend the Internal Revenue Code to base the income test for claiming deductions, credits, or exemptions on the adjusted gross income of the older person receiving support instead of his gross

income. This can be of particular help to low-income older people whose income is derived from small business operation or farming;

4. Develop ways of giving taxpayers who provide assistance to older relatives living in other households consideration comparable to that afforded when a needy relative is in the taxpayer's own home.

Private Sector's Role

One of the most strikingly unique elements in America's response to the needs of older persons has been the growth of private pension plans. No other nation has enjoyed the success that ours has in this voluntary approach to retirement income.

The private pension as an institution began roughly with the end of World War II. In the years since it has expanded rapidly, providing protection to an ever increasing number of America's citizens.

Its growth has shown that the people want to provide for their own retirement years as fully as possible and are willing to supplement Social Security and other government sponsored pension programs with their private savings.

Improvements during the past 10 years have included the widening use of tax incentives for retirement programs by the self-employed, such as farmers and small businessmen, and concurrent coverage of their employees. This development has taken a rightful place of importance alongside of the massive programs of large employers which continues with vigor.

Despite the progress to date, however, it is clear that much more needs to be done in the private pension field. Coverage needs to be expanded. Quality of coverage needs to be improved, both as to benefit levels and such problems as vesting of the individual's rights and portability of benefits from one employer to another need attention.

We recommend that efforts by the private pension industry to meet these challenges of income adequacy should be encouraged and assisted in every way possible.

Another area in which the private sector must of necessity assume primary responsibility is that related to expansion of employment opportunities for older Americans. This can be important in supplementing incomes. It also has important significance for preservation and maintenance of basic life values.

Gerontologists are increasingly impressed by the importance of meaningful activity as an essential ingredient in the happiness, health and well-being of older persons. For some this is compatible with total withdrawal from the work force. For others there remains a deep-seated need for employment, either in new occupational roles or old.

Often this need may be satisfied with part-time work. Sometimes its satisfaction demands full-time occupation, possibly at a modified pace.

Recognition of this has been given by both public and private agencies. Noteworthy among the latter has been the Mature Temps program sponsored by the American Association of Retired Persons and National Retired Teachers Association to bring employees and part-time older workers together in a mutually beneficial association.

The call of older Americans for increased employment opportunities and for changes in fixed retirement policies at arbitrarily selected

ages received maximum public attention at the time of the Eisenhower White House Conference on Aging 10 years ago. Despite the trend toward lower and lower average retirement ages, the call persists.

In hearings of the Special Committee on Aging, it has been reflected in expressions of gratitude by older persons who have participated in Federally supported limited work projects such as the highly successful Green Thumb program and Foster Grandparents program.

We recommend expansion of job opportunities, full-time and part-time, for older persons desiring employment.

We applaud and fully support efforts such as those by the Federal Government to fill the void left by loss of jobs simply because of age. We would like to see them expanded.

The fact is, however, that there will never emerge an adequate response to this human hunger among older Americans until the private sector recognizes that it has a responsibility that reaches beyond persons under 65 or 70.

Repeated studies have emphasized the quality and reliability of work performed by older persons. The skills—badly needed skills—which they possess have been well documented.

Neither private business nor the Nation can afford to waste these talents through nonuse. Until there is some new pattern in our economic life which will offer a place for older Americans, there will never be a development of modified retirement concepts suitable to the latter part of the 20th century.

It is our hope that the 1971 White House Conference on Aging will address itself to this need, that it will do so with the goal of involving the private sector of our society in a commitment to improve the latter years of life for all—including this matter of employment with its implications for both income and satisfaction of emotional and psychological needs of older Americans.

As discussed in previous Minority Reports of this Committee, there also needs to be recognition that employment problems related to age do not all begin at 60 or 65. For many persons, the problem becomes real as early as 40.

We recognize the important role the Federal Government may play in helping to solve this problem and support legislation for this purpose. We would be remiss, however, if we did not emphasize that here too is a place where the private sector has major responsibilities.

Importance of Research

We are deeply concerned with the problems of older Americans today. We believe in prompt action to expand opportunities for them to live satisfying, rewarding lives. But we also believe it is important that our national policy on aging take the long view into the future.

A major element in making the future brighter for the aging will be the extent to which we emphasize research and make sure that the end products of our research find practical applications in the lives of our citizens.

We strongly recommend adequate financing for research in the field of aging.

We believe that such research should embrace socio-economic elements of aging as well as those related to biological science and medicine. It should give appropriate consideration to all factors of the personality—emotional, physiological, psychological and spiritual—and to the changing nature of society.

Proposals have been made for expansion and emphasis on gerontological research in Federal programs such as those administered by the Institutes of Mental Health and for funding of gerontological research at the great universities such as is now being carried out at the University of Iowa, University of South Florida, Drake University, Duke University, and the Ethel Percy Andrus Gerontology Center at the University of Southern California. They deserve support.

The Ethel Percy Andrus Gerontology Center, incidentally, demonstrates the great concern of today's older persons with the importance of research to the aging of the future. The substantial financial support given to the center by members of the American Association of Retired Persons and the National Retired Teachers Association speaks for itself. Indeed, these two organizations were primarily responsible for the center's creation.

We recommend that such efforts be encouraged and reinforced by Federal support wherever practical. Congress should give prompt and careful consideration to appropriate funding to such research in aging at both the Federal and university levels.

As has been discussed in previous Minority Reports of the Committee on Aging, however, we also believe that there is need for coordination of research results as a means of maintaining effective national policies on aging.

We recommend creation of a mechanism for continuing in-depth study of economic, physiological, psychological and social factors in aging as a basis for evaluating policies and programs affecting older Americans of the present and the future.

Conceivably such a coordinating study mechanism could be made part of an improved Administration on Aging. Perhaps it should be separate. However it is done, the need is real and action on it should not be delayed.

Broadening Individual Horizons

Adequate incomes, medical care, housing and research are all essentials in giving meanings to the lives of the aging.

Older Americans know, however, that provision of the necessities, even with independence and dignity, often is not enough. Society has an obligation beyond this to offer opportunities for broadening of individual horizons.

Education, recreation, social activities and full opportunity to fill satisfying roles in the community are important to broadened horizons.

The need for personal growth, as attested by millions of older Americans, does not stop at any given age. The need for purpose in life may be as great at age 80 as at age 18.

There will always be a legitimate demand for a host of programs and services to assure the elderly that they will not become victims of isolation, loneliness, purposelessness.

Important among the needs related to effective involvement of older persons in the community's social life is transportation. It has often been cited as a major barrier to life-participation among the elderly. This is especially true when personal automobiles are not available to them.

We recommend serious consideration of this special handicap encountered by many older persons and development of transportation services which will open new doors and re-open old doors for active involvement of older Americans in our society's life.

We recognize that there are serious transportation problems facing citizens of all ages. We are encouraged by attention being directed at this problem by the Federal Government, States, and communities. We would make a special plea, however, that the answers which are developed for both urban and rural areas should give special attention to problems of the elderly. They should be given the essential gift of mobility.

Broadening of personal horizons of older persons also involves creation of new avenues for their participation in voluntary community activities.

We recommend expansion of economically feasible "second career" and volunteer service opportunities for continued involvement of retirees in the mainstream of community life.

Coupled with enlarged part-time or full-time employment openings suited to the needs, desires, and abilities of older persons, and more adequate retirement incomes, the result of greater volunteer opportunities can be immeasurable improvement in life-quality for older Americans.

We have been impressed with successes of the Green Thumb program, which employs older men in park and highway beautification and other rewarding work projects, and of the Foster Grandparents program which brings the warmth of human understanding and mature wisdom to children who would otherwise be short-changed. Both of these have provided income supplement to their older participants, but the Committee's record is replete with evidence that the personal satisfaction from these and similar programs has been at least equally important.

Such kinds of programs should be expanded to offer similar opportunities for life-fulfillment to more older Americans.

We are pleased at the proposed increase in funding for the newly authorized Retired Senior Volunteers Program (RSVP), and believe that its provision of money for "out of pocket" expenses by older volunteers will be important in giving them a chance for voluntary service which they otherwise could not afford.

It is impossible, of course, for the Federal Government to implement many of the most important programs related to the aging, particularly in areas of social-participation needs. Most of the work of this type must be conceived and carried out at the State and community level.

For this reason we believe it is essential that the work of the State commissions on aging be encouraged and strengthened. Within the limits of resources available to them, they have been most effective in helping to broaden individual horizons of older persons.

Most important has been their work through the community grants available under Title III of the Older Americans Act. Community level programs and activities—such as senior centers, homemaker services and friendly visitor services—have been important to hundreds of thousands of older Americans. It is through such grants that this Nation can best respond to the desire of the aging for essential recreational, educational and social activities.

We will comment further on this important element in a national policy on aging subsequently in these views. It is worthy of constant re-emphasis, however, that proper funding of community grants to the States through Title III of the Older Americans Act deserves high priority.

The most effective programs in social activity, education and recreation will be tailored to the special characteristics of individual communities. Decisions about them at the community level will reflect the wishes of the participants. Herein lies the beauty, perhaps the genius, of the Title III program and its essentiality to broadening personal horizons among older Americans.

Administration on Aging

Members of the Special Committee on Aging, without regard for geography or political affiliation, have long felt the need for an effective focal point for older Americans within the Federal Government.

With over 20 million persons past 65 and the multiplicity of Federal programs which can and should have an impact on their lives, it is most appropriate that there should be some agency within the executive branch of government to provide for coordination and emphasis on behalf of older persons, regardless of social and economic status.

That Congress, as a whole, shares our concern was manifest in unanimous adoption of the Older Americans Act of 1965 and its creation of the Administration on Aging headed by a Commissioner on Aging appointed by the President, subject to confirmation by the Senate.

Despite this clear mandate from the Congress, resistance by the Federal bureaucracy to provision of an effective voice for older Americans in the government persists. We are deeply disturbed by this negation of the people's will.

There should be prompt action, in whatever form is necessary, to eliminate this obstructionism.

The regretable attitudes of the Federal bureaucracy responsible for failure to meet the clear need for an effective coordinating agency concerned with older persons is not new.

The Committee on Aging report, "Developments in Aging—1963 and 1964", addressed itself to this question. Minority Views printed in that report said:

> How a philosophy alien to the desires of the people, and even contrary to the expressed purpose of the Congress, can influence administration of programs created to serve older people, is shown by review of the recent record of the Federal

Government's executive branch. Three examples suffice to illustrate the danger.

Administration attitudes are reflected in the decision, shortly after the end of the Eisenhower administration, by the Department of Health, Education, and Welfare to place its Special Staff on Aging and related activities under the Welfare Administration.

Prior to this change, the Special Staff on Aging had the status inherent in its being directly responsible to the Secretary of HEW, and through him, to the President's Council on Aging which President Eisenhower created to give Cabinet-level status to older people's problems and needs.

Despite repeated urging by Members of Congress in both parties, the administration has insisted in retaining aging activities within the Welfare Administration of HEW.

Undoubtedly the record referred to in the foregoing quotation was a major factor in enactment of the Older Americans Act of 1965 despite repeated testimony then against such an agency by the Secretary of Health, Education and Welfare.

Even this clear mandate from Congress failed to achieve its purpose. In August of 1967, then Secretary of Health, Education and Welfare John Gardner issued an order placing the Administration on Aging in a subordinate role under the Social and Rehabilitation Services Administration.

It is with deep regret that we take note of a continuation of this downgrading of the Administration on Aging at the present time.

We are greatly disturbed at proposed reductions in funding for the Administration on Aging.

While we approve proposed increases in funds for RSVP, the Retired Senior Volunteers Program, and area-wide projects, we must protest reductions in money available for other programs and the possibility that some may be removed from control of the Administration on Aging.

Reductions in funding for the Foster Grandparents program is serious. Reductions in funds for State Commissions on Aging to be used in community grants under Title III of the Older Americans Act is critical.

We and others have described Title III as the heart of the Older Americans Act service program.

Nothing has occurred to reduce the need for these valuable projects and activities which have brought additional values to the lives of so many older Americans. On the contrary, if there has been any change, it has been in the direction of increased need for them.

The effectiveness of the community grants under Title III has brought much valid commendation to the State commissions on aging. We heartily endorse their work and its extension. It is a vital part of the Nation's efforts to broaden horizons of older persons.

We recommend better funding of State commissions on aging with special emphasis on community level programs such as senior centers, homemaker services, meals on wheels, friendly visitor services, and educational, social, and recreational activities designed to combat the twin fears of aging—loneliness and frustration.

The point at which such additional funding should be applied is Title III of the Older Americans Act.

We again recommend upgrading of the Administration on Aging and strengthening of its ability to serve as a focal point for coordination of Federal activities and programs on behalf of older Americans.

We believe the intent of Congress on this important matter has too long been ignored. We believe that until that intent is reflected in appropriate action by the executive branch of the Federal Government, older Americans will continue to be shortchanged in essential services and a truly adequate and effectively implemented national policy on aging will be impossible.

Winston Prouty,
Hiram L. Fong,
Jack Miller,
Clifford P. Hansen,
Paul J. Fannin,
Edward J. Gurney,
William B. Saxbe,
Edward W. Brooke,
Charles H. Percy.

APPENDIXES

Appendix 1

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1: ADMINISTRATION ON AGING

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., January 29, 1971.

DEAR MR. CHAIRMAN: Complying with your recent request, enclosed is a report on the activities of the Administration on Aging during 1970. Also transmitted, for such use of it as you may care to make, is a set of the texts of my principal statements and addresses during the year.

Sincerely,

JOHN B. MARTIN,
Commissioner on Aging.

[Enclosure]

THE ADMINISTRATION ON AGING—1970

For the Administration on Aging, 1970 was, all in all, a busy and affirmative year, moving into what could be the most important year in aging, 1971. To summarize this report:

—A good beginning was made during 1970 toward strengthening statewide planning, coordination, and evaluation on behalf of the elderly, as required by the Older Americans Act Amendments of 1969;

—AOA and State agencies continued to cooperate in carrying out a variety of State and community programs which served hundreds of thousands of older persons;

—A number of pioneering research and demonstration projects developed new techniques and accumulated previously unavailable information in Aging;

—Training programs supported under title V became more solidly established during 1970, and their graduates were employed in signicant positions serving the older population;

—The Foster Grandparent program continued during 1970 as an exceedingly popular program for older persons, with a noticeable trend by States and others to fund positions like Foster Grandparents without Federal assistance;

—AOA initiated plans to establish one retired senior volunteer program (RSVP) in each of the 10 regions during 1971;

—AOA carried on an extensive information program, including information activities connected with Senior Citizens Month, May 1970;

—AOA began exploration with religious denominations of the possible involvement of churches in community services for older Americans through technical assistance from AOA.

STATE AND COMMUNITY PROGRAMS ON AGING

During 1970, funds were provided for two Federal matching grant programs under title III of the Older Americans Act:

1. Statewide planning, coordination, and evaluation on behalf of the elderly;

2. Community services, planning, and training on behalf of the elderly.

Both these programs are administered at the State level by designated State agencies on aging, which operate under approved State plans.

During 1970 new State plans were approved for Alabama, Indiana, Wyoming, and the Trust Territories of the Pacific Islands. This brings to 55. the total number of States and jurisdictions who are participating in and benefiting from programs under title III of the Older Americans Act. Only one jurisdiction eligible under the law, Samoa, is not currently participating in this program.

STATEWIDE PLANNING, COORDINATION, AND EVALUATION

State agencies on aging in this last year made significant strides in carrying out their new responsibilities for planning on behalf of the aged. These new responsibilities came as a result of the 1969 amendments (Public Law 91–69) to the Older Americans Act.

In order to proceed with the planning activity most efficiently and in accordance with National and State objectives, various "tooling up" functions were necessary.

Major processes involved in these functions consisted of the following:

1. Significant increase in staff capability—The average State agency full-time professional staff during fiscal year 1971 is estimated to be 5.5. During fiscal year 1969 the average was slightly above three.

2. New State plans—All States submitted new State plans in 1970 which incorporate: (1) the 1969 amendments; (2) provisions of the Intergovernmental Cooperation Act; and (3) the simplified State plan concept initiated by the Social and Rehabilitation Service. The State plans under the Older Americans Act were the first plans submitted under this new simplified concept.

3. Involvement of older persons—Each State is establishing or continuing an existing advisory committee on aging. At least one-half of the members of these committees are older persons themselves.

4. Reorganization—There has been a trend for State agencies to organize into multipurpose departments dealing with a variety of health and welfare problems at the State level. Thirty-three State agencies are now located in such multifunctional departments, and 22 independent agencies.

5. Coordination with other State agencies—There has been a significant increase of State agency involvement with other State agencies, especially State planning agencies. State aging agencies are in many States represented on inter-agency advisory committees. Such coordinated activity for programs to better benefit the elderly has already had positive results—in legislative proposals, joint funding of projects, etc.

With the organizational and other basic functions completed or well underway, States began their actual planning activities.

The first phase of State agency planning is the collection and analysis of data on the aged population, and on programs for the aged in the State. These data collection activities are set forth as requirements in the Federal regulations for all States. All States are therefore working on:

1. The completion of a comprehensive study of the status and needs of the elderly in the State; and

2. The completion of a report on achievements of State programs for the aging in the State.

As one part of the data collection activities, all States have conducted public hearings on the problems and needs of the aged during the past year.

In addition to comprehensive studies, many States have initiated special studies to research in depth some of the major problems and situations affecting the elderly. Examples of such special studies include studies on health of the elderly, mental hospitals, housing of the elderly, nursing homes, and tax burdens on the elderly. These various studies have begun to pay off in that State agencies on aging have the facts when they go to other agencies to press for improved programs for the elderly.

The State agencies on aging have conducted these planning activities along with their many responsibilities related to the White House Conference on Aging.

The Older Americans Services Division of the AOA has taken on the responsibility of providing State agencies on aging with tools to help them in their planning tasks. During 1970 one such major tool, "Social Indicators for the Aged, A Guide for State Agencies on Aging," was produced. This guide consists of a comprehen-

sive survey questionnaire and a social indicator methodology to help interpret the results of the survey in major subject areas. Another tool, the "State Data Book on Aging," is currently in the final stages of development.

COMMUNITY PROGRAM ACTIVITIES

In fiscal year 1970, 1,800,000 older persons were served by 1,000 projects under title III of the Older Americans Act.

Title III community grants are awarded by State agencies to strengthen existing community services for the aging and to stimulate new community interest in meeting the identified needs of their older residents. The following were among the services provided:

1. Services for independent living—In 1970, 165,264 older persons were helped to maintain independent living arrangements through services which fostered independent living. These in-home and out-of-home services played an important part in helping older persons maintain their own independence in the community in surroundings familiar and congenial to them, and often at considerably less cost than the more expensive alternatives of nursing home care, hospitalization, or institutionalization. Homemaker-home health aide services were provided to 19,477 persons by projects in 32 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

Home maintenance or "chore" services, friendly visiting and telephone reassurance were provided to over 100,000 persons. Many of the services were provided by older persons themselves.

Home-delivered and group meals were provided for 25,912 elderly persons in 36 States, the District of Columbia, Puerto Rico, and the Virgin Islands. The average cost for home delivered meals was $1.25. However, the majority of older persons receiving this service were unable to pay the cost and could not have received it without these programs.

Adult day care programs in Baltimore, Md., and St. Petersburg, Fla., provided valuable and flexible services for older persons such as meals, snacks, health services and therapy, and the opportunity to participate in recreation, arts and crafts, and educational programs. Because of these programs, their relatives or caretakers could continue to work without worry, shop for themselves and other members of the family, and obtain surcease from the constant daily care of elderly individuals. The elderly themselves benefited from the supervision, care, and help provided in the protected setting.

2. Opportunities for participation in community life—Improved quality of life results from other services offered by many title III projects, in seeking to provide opportunities for older persons to continue to lead active and meaningful lives in the community. Employment opportunities were provided for older persons interested in or needing to supplement social security and other benefits, or utilizing special skills to supplement income after retirement. Some 528,713 elderly persons participated in recreation and other leisure type activities under title III. These activities were as diverse as the interests of the older persons themselves, and ranged from the opportunity to read a paper or a book in a quiet corner, to birthday parties, songfests, covered-dish dinners, to trips to other centers or points of interest. Adult education activities were offered to more than 100,000 older persons. Transportation services were provided to some 88,059 elderly individuals. Transportation is a major problem for the elderly, particularly in rural areas, as it limits the ability of older persons to obtain the necessities for daily living, such as medical and dental care, to visit friends or relatives, or to participate in a variety of activities with others having similar needs or interests.

One project purchased surplus schoolbuses to provide transportation to senior citizens at a nominal cost. Another project purchased a mini-bus to transport older persons to shopping centers, senior centers, clinics, and hospitals for medical care.

With assistance under title III, State agencies also provided support for some 468 senior centers, which served some 600,000 older persons in fiscal year 1970. These centers provided opportunities for participation and active engagement in community life, and offered many of the services needed to help the elderly maintain independent living arrangements. The senior center has often become the focal point for planning, developing, coordinating, and delivering services to the aged in the community. It is frequently the channel for contact and communication with the elderly in the community through its information and referral and outreach programs. The elderly, through participation and involvement, became aware of and knowledgeable about resources of the community and the gaps in

the services which they as a group may help to meet. Senior centers are located in housing projects, churches, public and private buildings, and many provide a wide range of services and/or opportunities for older persons. Frequently, older persons themselves provide services to other persons, old and young. Some senior centers have satellite centers located in neighborhoods where older people live. These satellite centers provide and deliver a myriad of services tailored to the special needs of the elderly in the community.

3. Volunteer opportunities—The interest of older persons in volunteering in title III projects has been significant. Some 50,000 older volunteers are providing a variety of services in their own communities. The young, the aged, families, institutions, and other community groups are the beneficiaries of these services. Senior volunteers assist in operating senior centers by directing leisuretime activities, staffing information and referral programs, making contacts with residents in an outreach program, providing tutorial services for students, visiting and helping the homebound, providing transportation for the elderly so they may shop, obtain medical care, attend church, or obtain other needed services or resources. Volunteers also provide telephone reassurance to the isolated, ill, and handicapped older persons. In serving others, older volunteers broaden their own interests and add new meaning to their own lives.

In one project in California, volunteers seek out hard-to-reach individuals who are isolated economically, socially, culturally, or geographically. They provide in-home and out-of-home services, companionship, and a link to the resources and people in the community. In a number of centers located in housing projects, older volunteers teach arts and crafts, prepare and serve hot noon meals to residents, visit and assist the chronically ill in maintaining their own living arrangements, shop, cash checks, pay bills, and perform other necessary tasks.

In Rhode Island, the entertainment program for institutionalized elderly is now in its fourth year of operation. It has provided entertainment programs for hundreds of institutionalized elderly persons who look forward to each performance with anticipation. In addition to those elderly who donate their talent, young talented performers such as dancers and choral groups, also donate their time.

Business and community leaders provide money or goods to be used by performers or distributed to institutionalized persons. The Rhode Island Veterans' Home and Veterans' Hospital in Providence views this program as a needed service.

4. Training of personnel—A total of 71 title III training projects during the fiscal year 1970 provided short-term training for over 15,000 persons to serve the elderly. Many of the projects prepared specialized personnel, professional and nonprofessional, to better serve the elderly. Delaware's geriatric aide program is training and locating employment for aides who serve the elderly in their own homes.

In Washington, 50 persons were trained in two programs (lasting 1 week each) in basic biological, sociological, cultural, and economic aspects of aging, so that they could work more effectively with programs for the elderly.

In Arizona, 72 persons, including 35 older persons, were trained in general home care, to provide in-home services to the elderly in a rural county. Receipt of these services frequently enabled older persons to remain in their own homes and in many instances delayed institutionalization or nursing home placements.

5. Community planning—During fiscal year 1970, 141 title III projects were engaged in planning programs and services for the elderly in their communities.

In North Dakota, a statewide community organization project has initiated 73 activity programs through clubs and centers for older people in the State, and is now developing county councils on aging.

In New Jersey, the Paterson office of aging developed a senior center with no additional Federal funding but a great deal of volunteer help; developed a nutrition program, separately funded under title III, which now serves lunch to 135 older people per day and delivers meals to 25 homebound elderly; and developed a podiatry program initially funded by the State division on aging out of State funds. Using this podiatry program as an example, the division on aging has now determined that similar programs can be funded by local health departments as certified health services for which they receive on-going partial State health reimbursement.

In Bergen County, N.J., the local office of aging helped in the development of a small title III grant to the county department of transportation. This grant not only provided summer transportation for the elderly, but also led to a change in the admission policy to county parks, which are now free to older people.

6. AOA model cities activities.—Approximately one-third of all Americans 65 and over live in central cities. The Administration on Aging has devoted an increasing amount of attention to the needs of the elderly in model city areas. Since the elderly in model city areas suffer from problems of poor housing and lack of transportation and mobility due to low income, accessible services are of vital importance to them. Increased health and social services are critically needed.

The AOA activity in model cities programs is quite broad. AOA has its own task force in model cities, and within AOA programs under titles III, IV, and V have given high priority to model city needs. AOA, through agreement between HEW and HUD, has moved ahead on programs for the elderly in concert with the model cities administration.

In 1970, 116 title III funds in the amount of $2,407,480 were approved by State agencies for planning, services, and training of personnel to serve the elderly in model city areas. State agency personnel, whose administrative expenses are met in part by title III funds from AOA, have provided active leadership in identifying and meeting the needs of the elderly in model city areas. A number of State agencies have sponsored meetings on model cities and the elderly, to bring together representatives from AOA, the Office of Economic Opportunity, the Departments of Labor and Housing and Urban Development, universities, staff of the city demonstration agencies, elderly and other neighborhood residents. Action plans for assuring that the older model city residents participate in the planning of the model city programs were formulated in these meetings.

Research and Demonstration

R. & D. project grants under title IV of the Older Americans Act are contributing significantly to knowledge and improved practices in aging. During fiscal year 1970, 61 new and continuation projects were funded at a cost of $3,082,000.

Funds under this program have been used to support projects designed to examine the major needs and problems of the Nation's elderly population, and to develop better ways of dealing with them.

A number of pioneering projects are developing new techniques and accumulating previously unavailable information in the general area of aging and its relationship to social arrangements and organization within the larger society. Some major problems being pursued are: evaluation of the impact of Federal, State, and local research, development, demonstration, and service programs on older people; means of organizing areawide information and referral services for older persons; development and testing of new approaches to planning and coordination of services to older people within model cities neighborhoods; development of a series of social indicators for State and local use in setting program priorities, goals, and formulating policy for aging; and the evaluation of public and private organizational structures designed to serve older people.

Significant new knowledge was developed by many of the projects. For the first time, systematic information became available on transportation-related needs, problems, and behavior of older people; the efficacy of a variety of volunteer service roles for older people in implementing major Federal and other social programs in a variety of organizational settings were demonstrated; the complex legal-social area of protective services was further defined and clarified; and the effectiveness of group meal services for improving the nutritional status of older people, as well as their social and personal well-being, was verified through the results of a number of previously funded projects. Seven different national seminars and workshops increased the prompt utilization of project findings by practitioners, researchers, policymakers, and administrators representing a broad range of agencies, organizations, and institutions.

Nutrition

In 1968, Congress earmarked $2 million to establish under title IV a special program to improve nutrition services for the elderly. This program supports demonstration and research projects designed to test techniques and delivery systems that not only improve participants' diets, but also enhance the feelings of self-esteem and self-reliance which are so closely related to good nutrition. Grants have been made to nonprofit public and private institutions, organizations, and agencies serving the aged. Ten projects have already been completed. Of the 22 projects now in operation in 17 States and the District of Columbia,

19 are demonstration projects and three are devoted to research. Demonstration projects also include research components.

Research is directed at examining the effect of loneliness on meal preparation and consumption by the elderly; the effect of social isolation on their food habits; the impact of nutrition education programs; and the ways in which the elderly are influenced by their involvement as volunteers in the nutrition program. Programs are also designed to collect data on the various methods of motivating the aged to improve their eating habits and to provide demographic information about program participants.

The demonstration projects differ from community to community. They serve a variety of socio-economic groups: the poor, the not-so-poor, elderly people living in isolated nonmetropolitan areas, and those living in the crowded central city, representing all races and ethnic groups.

Despite these variations, it became clear as the programs evolved that all projects should include five basic elements if they were to be responsive to the realistic needs of the elderly: (1) Reaching out into the community to locate those in need of the program; (2) serving meals; (3) building nutrition education into the program; (4) providing a variety of related ancillary services; and (5) establishing a mechanism for systematic and objective evaluation. These elements have gradually been built into the title IV demonstration nutrition projects.

In addition to these basic components, other techniques to meet the nutritional and related needs of the elderly are being tested and evaluated in many projects. Take-home meals for weekends, potluck dinners, weekend dining arrangements; delivery of meals, mealtime companies and friendly visitors for the homebound; information and referral services; and leisure time and recreation activities. Transportation is provided where the elderly do not live within easy walking distance of the project.

Existing facilities in the community such as schools, recreation, community and senior centers, homes for the aged, and social halls in public housing and churches provide the setting for the projects. Staff includes professionals, volunteers and paid employees, part-time and full-time, the elderly and the young. Almost all projects employ senior citizens.

Data available at this time indicate that the nutrition problems of the elderly cannot be fully dealt with apart from their social and health needs. Moreover, virtually all directors of the Administration on Aging supported nutrition programs agree that such ancillary services as transportation and outreach are essential to the success of a nutrition program for older Americans.

Two major causes of malnutrition and undernutrition in America are lack of income and ignorance of what constitutes an adequate diet. In addition, other social and psychological factors associated with aging adversely affect the dietary habits of older people.

Findings further indicate that the meal in a group setting often is the drawing card to bring lonely and isolated elderly into a whole range of community activities. It also becomes the occasion for acquainting them with the availability of other services, or, indeed, providing such services. In such a setting, experience indicates that food-nutrition services and social-health services become mutually reinforcing in meeting the totality of the needs of elderly participants.

RETIREMENT LIVING

Senior citizens' self-help and mutual assistance potentialities are being explored through a number of projects that are involving older people in a variety of helping roles designed to enhance the well-being of other groups of senior citizens. These projects are supplying essential knowledge in regard to means for sustaining the aged in meaningful and productive social roles beyond retirement from the labor force.

Preliminary data from these projects indicate that viable roles, such as those of teacher aides, library aides. representative payees, outreach workers, etc., enhance the older person's opportunities to adjust to the social, economic, and psychological phenomena of aging and retirement, and significantly strengthen his ability to live an independent, active life in the community. A common thread, woven throughout all of these projects was that, to many participants, the financial reward—much as they needed the income—was secondary to the opportunity to be useful and to associate with others.

Researchers at the University of Oregon found an emerging trend toward early retirement. The majority of companies surveyed neither encourage nor discourage

the employee in his decision, and few companies use the provision as a means of work force control. The overall conclusion was that preretirement counseling as practiced in the companies studied seemed to positively affect the adjustment of retirees, weakened the resistance of the older employees to retirement, and contributed significantly to better morale and job-related attitudes among employees in the last years before retirement.

MOBILITY-TRANSPORTATION

Two projects in the area of mobility-transportation have indicated that senior citizens increase their use of local public transit facilities when the transit companies lower fares for this group. In addition, these studies have shown that this increase cannot be attributed to the same older people riding more frequently, but rather, to new users taking advantage of a real savings. These studies also reveal that with the exception of employment-oriented trips, older people and especially low-income older people, use public transportation proportionately more frequently than the general population.

SOCIAL ISOLATION AND SOCIAL TRENDS

A project designed to develop, test, and accumulate a set of social indicators for aging will assist in the ongoing assessment of the status of older Americans. These indicators promise to be extremely useful for guiding the formulation of Federal and State legislation, assisting State agencies in comprehensive planning and coordinating programs, identifying current needs of the elderly, assisting the evaluation of existing programs at State and Federal levels, establishing goals and priorities for services to the aging, and helping to focus national attention on problems of older people.

In Nashville, Tenn., a pioneering research project is investigating whether, and to what extent the kinds of social relations sustained by elderly persons, especially the low-income aged, determine the style of their lives and thus the degree to which they are physically mobile and avail themselves of social and community services. The analysis of the data will yield information valuable for answering questions relating to the development of transportation services for older people and for developing systems for the delivery of social and health services to various type of elderly.

A project in San Diego, Calif., has demonstrated that an independent community unit can serve as the coordinating mechanism for focusing a wide variety of protective resources on impaired older persons. The project is providing clarification of the legal, medical, and social responsibilities of protective services programs and discovering ways of reaching those in need of protective services and how they may best be served.

A research project in Kansas City, Mo., is focused on the relatively isolated and lonely older persons in the inner city, including a model cities neighborhood. Analysis of the data is providing systematic descriptions of the life styles of the socially isolated and lonely and of the programs of action that are required to assist them—programs identified by the respondents themselves as well as by professionals.

TRAINING

Title V supported training programs conducted in 18 universities spread across the country became more solidly established during 1970. Graduates were employed in significant positions in an expanding range of categories and organizations serving the older population. Opportunities for student internships increased markedly. Faculty and students in most of the programs became involved in White House Conference on Aging activities. The two programs which have become recognized training-research service centers expanded their activities and spheres of influence. Four training publications and several films were issued by the Administration on Aging or by grantee institutions.

The majority of the time of the title V staff was devoted to the overall social and rehabilitation service effort: (1) A closer integration of all SRS training programs and (2) decentralization to the regional offices of much of the responsibility for program monitoring. As a result of redefinition of functions, the AOA training program became more involved in staff development for Federal and State agency personnel.

Most of the funds available in 1970 were awarded for the support of career training during the 1970–71 academic year. Faculties in the training institutions demonstrated increased commitment to the field, the number of applicants far exceeded the traineeship offered, and most of the institutions reported enrollment of nonprogram students in gerontology courses.

The emphasis on career preparation largely at graduate levels was consistent with the widely held conviction that one of the greatest deficiencies in the field of aging lies in the shortage of personnel equipped with a basic knowledge of gerontology coupled with skills in administration, planning, program conceptualization, and evaluation. The title V program is able to focus on preparation of personnel for these higher level tasks because funds for vocational education, short courses, and inservice training of complementary personnel are available from Older Americans Act, title III funds administered by the States, vocational education, MDTA, and Economic Opportunity resources.

Title V support for long-term education and for short-term training, development of teaching materials, and manpower studies is shown in table 1 from the beginning of the program through 1970.

TABLE 1.—PROGRAMS AND SUPPORT FOR TRAINING FOR PROFESSIONAL SERVICE IN AGING, FUNDED UNDER TITLE V OF THE OLDER AMERICANS ACT, 1966–70

[Dollars in thousands]

Year	Programs			Aggregate amount of awards		
	Total	Long term	Short term	Total	Long term [1]	Short term [2]
1966	12	2	10	$420	$136	$284
1967	23	8	15	1,330	853	477
1968	30	13	17	2,220	1,701	519
1969	28	17	11	2,845	2,558	287
1970	16	15	1	2,601	2,601	6

[1] For the years 1967 through 1970, some of the projects for which grants of a predominantly long-term nature were awarded included some short-term components, as explained in the text which follows.

[2] Short-term includes training projects less than 1 year in length, manpower studies, preparation of training materials, curriculum development.

The 15 long-term programs and one short-term program among which 1970 funds were distributed involved 18 universities. Two of the long-term awards were made to the University of Michigan-Wayne State University Institute of Gerontology and to the jointly operated University of Oregon-Portland State University program. The 13 other long-term programs are located at:

Arizona, University of
Brandeis University
California, University of
Chicago, University of
Columbia University
Minnesota, University of
North Carolina, University of
North Texas State University
San Diego State College
South Florida, University of
Southern California, University of
Washington, University of
Wisconsin, University of

The short-term program for retirement housing administrators offered by the University of Georgia received support. Four short-term projects which had been funded for several years reached the end of the approved project periods and were not refunded.

Authorized expenditures in the 1970 awards aggregated $2.904,000 or $297,000 more than the amount of new funds available. This $297.000 in additional funds was the amount carried over from 1969. Careful stewardship resulted in unexpended balances of 1969–70 funds in several institutions. The balances were applied mainly to the support of additional traineeships. The reduced 1970 appropriation made it impossible to support any new programs although several additional institutions were ready to enter the gerontological field.

The dollar figures for short-term training as shown in table 1 does not reflect accurately the amount of funds awarded for such training in the years 1967 through 1970. Approximately 45 percent ($318,000 in 1970) of the expenditure authorized for the University of Michigan-Wayne State University program was designated for support of the highly successful 14-week residential institutes and Milieu therapy demonstrations and short courses described below.

Institutional support accounted for 30 percent of the 1970 funds awarded. Student benefits have risen to 70 percent of total expenditures from AOA funds as the programs have matured and developed capabilities for accepting increasing numbers of trainees. The universities are under continuing pressure from AOA to assume increasing proportions of institutional costs. Limited State appropriations have made it impossible for many of them to respond. Thus, it is apparent that the Federal Government will have to continue its leadership role if older people are to be served by properly trained personnel.

TRAINEES AND GRADUATES

The numbers of persons reached directly by programs supported under title V during each year are shown in table 2. The rapid growth in career students is indicative of the need tapped by the programs and of the willingness of young and middle-aged persons to prepare for service to the older population. The numbers of employed persons seeking to improve their qualifications for work with older people through short-term training is also encouraging. The 50-percent decline in short-term trainees reflects the drop in funds shown in table 1.

TABLE 2.—CAREER STUDENTS AND SHORT-TERM TRAINEES IN AOA-SUPPORTED PROGRAMS, 1966–70

Year	Career students and short-term trainees		
	Total	Career students	Short-term trainees
1966	934	12	922
1967	1,024	78	946
1968	1,689	214	1,475
1969	2,114	363	1,751
1970	1,220	370	850

All AOA-supported programs require students to obtain field placement experience as a part of their training. More than one-half of the programs call for a block placement of 3 to 9 months. The training institutions are reporting increasing success in locating agencies and organizations willing and often eager to accept students as interns. A significant breakthrough occurred in 1970 when the Social and Rehabilitation Service made available a number of positions for trainees of AOA and other SRS-supported training programs. The title V staff negotiates for student placements in SRS central and regional offices, holds periodic interviews with trainees and their preceptors, and arranges for students interning in Washington to attend congressional hearings and relevant agency meetings.

Graduates of the advanced level programs now number well over 100. A study currently in progress reveals that they are being employed in Federal and State agencies in aging; State health and rehabilitation agencies; community, including model city programs; housing projects and homes for the aged; senior centers; national voluntary organizations; universities; and in the United Nations. Several are working for higher degrees.

The residential institutes offered by the Institute of Gerontology at the University of Michigan-Wayne State University continue to draw more applicants than can be accepted. Since their inception in 1967, seven institutes offering 14 weeks of intensive training have been conducted in the areas of retirement housing management, multiservice centers, Milieu therapy, public policy; planning and programing, and preretirement education methods. Through December of 1970, there had been 176 trainees recruited from over the entire country. Virtually all of the trainees have had previous work experience; one-third attend the institutes on educational leave from employing agencies. Median age of the trainees is between 35 and 39 years; 60 percent have been women; a significant number have been representatives of minority groups. One-third of the trainees have had less than a college education; hence, are using the institute experience to move upward into jobs carrying professional responsibility.

WHITE HOUSE CONFERENCE INVOLVEMENT

Numerous faculty members and students in AOA-supported programs became involved in the White House Conference on Aging during the 1970 prolog year. Students from most of the programs attend older American com-

munity forums in September, interviewed older people, and prepared reports for the national WHCA office. In some instances students assisted community leaders in organizing and conducting forums. Several of the training programs sent one or two students to Washington to participate in technical committee meetings. Two students had field placements with the WHCA.

Faculty personnel are members of national technical committees for the conference and many are serving on State WHCA task forces. Three have prepared background papers for the conference, and a number are assisting State agencies on aging in training personnel for community and State conference leadership roles.

Three graduates of AOA programs occupy positions on the national WHCA staff. A former program director serves as conference technical coordinator. The director of the title V program is associate coordinator for WHCA technical committees.

UNIVERSITY GERONTOLOGY CENTERS

The University of Oregon-Portland State University center moved beyond its long-term training programs to offer short-term instruction in methods of retirement preparation, made the lectures in the perspectives on aging series available to community audiences in Eugene and Portland, developed field experiences for undergraduate students, and provided consultation to community agencies and organizations. The Portland State University faculty is assisting the Oregon State program on aging in the WHCA effort.

The longer established University of Michigan-Wayne State University Institute of Gerontology—supported in part with legislative appropriations—expanded its services to the State and the country. With the assistance of title III funds awarded by the State commission on aging, the Institute of Gerontology entered the third year of its faculty seminars for personnel of Michigan's colleges and universities. As of the fall of 1970, some 15 of these Michigan institutions were offering an aggregate of 80 instructional units on aging. Eight of these are developing specialities in aging. Personnel of two institutions conducted inventories of personnel needs in their catchment areas.

The staff of the mental hospital Milieu therapy project at the Ypsilanti State Hospital conducted 15 1- to 3-day programs for 810 mental hospital personnel from all parts of the country in addition to 14-week Milieu therapy residential institutes. Results of these activities are seen in better treatment and restoration of aged persons hitherto destined to round out their lives in drab mental hospital environments. Short-term programs in retirement preparation leadership and church roles in aging were conducted for several groups.

The Institute of Gerontology undertook to close another gap in the field by inaugurating a nationwide placement service in aging. The service maintains a list of job openings and of personnel available. It has been instrumental in matching AOA-supported graduates and others with jobs suited to their training and capabilities.

Increased support for university-based gerontological centers could be one of the most fruitful developments in the aging field. A number of qualified universities are ready to develop centers when funds become available.

PUBLICATIONS

Most of the publications and films, noted in previous reports to the Senate Committee on Aging, were completed and published in 1970. The Administration on Aging published "Basic Concepts of Aging: A Programed Manual," developed by faculty of the University of South Florida training program. More than 3,700 copies have been distributed on request. An account of a University of Denver 3-year experiment in providing field experience to students in a course on the sociology of later maturity was published in AOA's new Patterns for Progress in Aging series under the title "A Plan to Span."

The University of Oregon completed a set of video tapes of perspectives in aging lectures for use in classroom teaching and NET. A 28-minute color film entitled "The Therapeutic Community," and exposition of the University of Michigan's Milieu therapy program in a State mental hospital, is being used widely in the United States and in Japan and several countries of Western Europe. A visual essay, "A Therapeutic Milieu for Geriatric Patients," became available for purchase. Work is nearing completion on a 1-hour teaching filmstrip, "Developing a Therapeutic Community for Mental Hospitals."

The George Washington University Department of Health Care Administration completed texts for two courses in social gerontology. The courses were introduced into the university's home study program for administrators of long-term-care facilities.

COORDINATION AND REGIONALIZATION

The Social and Rehabilitation Service moved rapidly during 1970 to coordinate and integrate its several training grant programs and to give the regional offices more involvement in them than they previously had. Dictating considerations were: A desire to achieve increased effectiveness in providing manpower for SRS-related programs, need for coordination of overlapping program objectives, and standardization of procedures and institutional performance.

The new SRS Office of Manpower Development and Training consolidated fiscal control of the grant programs, developed standard procedures and application forms, initiated studies of manpower needs, and plans for continuing program evaluation. Decentralization of certain functions is designed to make SRS training programs increasingly responsive to regional, State, and community needs. Regional offices accepted responsibility for monitoring ongoing training programs, for reviewing new training proposals, and for making grants for short-term projects aimed at meeting regional manpower requirements. Central office program agencies continue to make awards for new long-term programs and short-term projects of national import, will participate in manpower studies, and step up their responsibilities for staff development in SRS-related agencies at State and community levels.

Most of the title V staff time during 1970 was devoted to working with SRS committees and task forces on the formulation of plans, procedures, and training strategies related to coordination, regionalization, and evolving SRS objectives.

The AOA staff conducted a 3-day institute on the AOA mission and programs for central and regional office personnel, and worked with a grantee institution in conducting three 1-week intensive training institutes in systematic program planning and evaluation for personnel of State agencies on aging.

FOSTER GRANDPARENT PROGRAM

The foster grandparent program continues to be an exceedingly popular program for older persons. The program was first developed in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. The program was administered jointly from then until September 17, 1969, when the Older Americans Act Amendments of 1969 (Public Law 91–69) became effective. These amendments provided for the complete transfer of the program to the Department of Health, Education, and Welfare, where it is now being administered by the Administration on Aging. Various program activities have now been decentralized to the Department of Health, Education, and Welfare regional offices where Social and Rehabilitation Service regional commissioners have responsibility for program review and funding as well as offering consultation and technical assistance to the foster grandparent program grantee agencies. The national office of the program as part of the Administration on Aging continues to maintain responsibility for planning, policy, evaluation, coordination, public information, and legislative activities; it also offers consultation and technical assistance to the regional offices.

The purpose of the program when it was initially established was to explore, evaluate, and demonstrate the feasibility and the potential benefits of using the services of older persons for the enrichment of the social environment of institutionalized infants and young children. That premise was almost immediately established and the program concept has expanded to serve children in a wider range of settings including correctional institutions, hospitals, mental health clinics. Headstart classrooms, day centers, and classes for exceptional children. National authorities on child care have commented on the excellence of the foster grandparent program. Dr. Maria Piers, dean of the Erikson Institute for Early Education and author of "Wages of Neglect," has stated:

> "As a preventive program, foster grandparents is the best thing known to combat the pernicious influence of neglect.
>
> "Children who are ignored, cut off from adult contact and love can face a total deterioration of the intellect with lifelong crippling effects.
>
> "Foster grandparents give the children the warm, loving contact with adults that is so necessary to their growth and development.

"We have seen the positive results of this program. Every institution or agency caring for children could benefit from the work of a foster grandparent in every child care unit."

Institutions and agencies caring for children have actively responded to the program; literally hundreds of requests for Federal help to start new projects are turned away each year for lack of funds.

Since the funding of the initial 21 projects in 1965, the program has expanded to include 68 projects, in 40 States and Puerto Rico. No new programs were funded in 1970. Currently, there are approximately 187 participating institutions and child care agencies in which 4,300 foster grandparents serve 8,600 children on any one day. Approximately 5,400 older persons serve as foster grandparents during any one year, serving as many as 22,000 different children.

Foster grandparents serve 4 hours a day, 5 days a week and receive a stipend of $1.60 per hour; they are reimbursed for their transportation cost and, where possible, are provided with a nutritious meal daily. Foster grandparents are also covered by workmen's compensation or a similar type of accident insurance, and each foster grandparent receives a physical examination yearly. At least 83 percent of the total program budget is spent as direct benefits to the foster grandparents. However, one of the distinguishing features of the program is in the area of social services; through the professional staff of each individual program, foster grandparents receive counseling on personal matters and information regarding benefits available through medicare, social security, legal services, and community and other Federal programs.

And beyond the above, the foster grandparent program offers to the older persons all that makes us most human—communication, self-awareness, sympathy, conscience; it gives the older person an opportunity to serve and be served, to love and be loved, to achieve happiness in striving to meet moral responsibilities in relation to and in interaction with other human beings.

The foster grandparent program is a program of great potential. The position of foster grandparent could very well become part of the regular personnel roster of many institutions and child care agencies serving children. That is, a pediatric hospital or center for neglected children could allot, out of its budget, a certain fraction of money in order to procure the services of a certain number of senior citizens to serve as foster grandparents. This has already been accomplished on a very modest scale by certain States. For example, Illinois, Iowa, and Delaware funded 81, 60, and 84 foster grandparent positions; Pennsylvania appraised the need for such grandparents at about 5,000 and has funded 61 positions. The Administration on Aging knows of a total of over 600 positions similar to foster grandparents, which are not funded by the Federal Government. There are reasons to believe that other communities have developed similar opportunities that have not been brought to the attention of the Administration on Aging.

The foster grandparent program has provided many insights into the potential utilization of the elderly in community settings. It has not only provided low-income older persons with a drastically improved standard of living but has demonstrated to communities that older persons have the talent, skill, experience, ability, and desire to serve their communities by meeting some of the unmet human needs in the community. Thus the benefits resulting from the foster grandparent program extend far beyond the direct gains to the children and foster grandparents who have participated.

Retired Senior Volunteer Program

The retired senior volunteer program was authorized by the Older Americans Act Amendments of 1969. $500,000 was appropriated early in 1971, permitting the Administration on Aging to initiate plans to establish one senior volunteer program in each of 10 regions in 1971. A study of existing senior volunteer programs was embarked upon during the last 6 months of 1970, to assist in a realistic formulation of regulations and guidelines.

Information Activities

During the first half of 1970, AOA's Information Division concentrated on major items for Senior Citizens Month (May 1970), and assisted in the preparation and issuance to the press of statements and speeches by Commissioner John B. Martin, who had a full travel and speaking schedule.

Major publications for Senior Citizens Month were:

- A special preprint of Aging magazine featuring graphic presentation of statistics on aging and summary of Older Americans Act progress. This was reprinted later with additional charts included from the final May issue.
- A President's Proclamation and a poster, both featuring 1970 as "Prologue Year to the 1971 White House Conference on Aging."
- A new signature publication for the agency, "Every Tenth American," covering the philosophy and mission of AOA and its major programs in one small, easily mailable leaflet.

For Senior Citizens Month, some half-million pieces of mail-publications, posters, proclamations—were distributed by the AOA Information Division through regional offices of HEW, State agencies on aging, other Federal agencies and national organizations. The Senate Special Committee on Aging was provided with 20,000 pieces for a major mailing it undertook.

In addition, special background material, fact sheets, radio and TV spots (text), were provided to media and organizations for their development of articles and programs of their own. The Advertising Council again supported the endeavor through its Media Newsbulletin for April–May.

Outstanding media contribution was a five-broadcast Today Show series, May 11–15, arranged with NBC. The visual background featured the AOA poster adapted to the show. Commissioner John B. Martiin was the guest on the wrap-up final show with moderator Hugh Downs.

The division also arranged, scripted, and assisted in production of two half-hour television programs in the "You" series of NBC featuring HEW programs—"You and Your Future" and "You and the Calendar." Tapes of these programs were transferred to film and distributed to regional offices and through them made available to State agencies on aging for use during Senior Citizens Month and beyond.

With the filling of several vacancies in late spring and early summer, the division was able to provide a number of major tools for regional and State offices concerned with aging. Particularly important was a start made on long-needed exhibit and audio-visual materials.

New publications—either issued or at press at the end of 1970 with early delivery date included:

- "The Older Americans Act as Amended," with the 1967 and 1969 amendments in place within the act, accompanied by a short history;
- New bibliography on aging "Words on Aging" (A supplement, covering publications of 1969 and 1970 will be completed and issued before the November 1971 White House Conference on Aging);
- New and current AOA publications list;
- The first of a new format in the old "Patterns for Progress in Aging" series. (This one, "A Plan to Span," reporting upon a work-study program made possible by any AOA training grant to the University of Denver under which undergraduate liberal arts students did their fieldwork in active service to older people. It has been effective in changing attitudes, helpful in closing some of the generation gap, and, in a number of cases, opening up new career possibilities in aging to students);
- First foster grandparent leaflet developed since transfer of the entire operation of the program to AOA;
- "Basic Concepts of Aging," a programed learning booklet on attitudes developed by the University of South Florida with an AOA title V grant; and
- Major compilations and reprints of materials pulled together on such subjects as "Nutrition," "Transportation," "Model Cities," and "Older People as a Resource."

The Division began revision and updating of a "Film Catalog on Aging," not available since 1965—completing circularization of producers late in the calendar year.

As noted, it has also been able to make a long-anticipated beginning in preparation of exhibit materials for regional offices and all State agencies on aging, to provide table-top exhibits and interchangeable posters on a variety of subject areas, all related to the White House Conference on Aging's agenda and needs of older people—adaptable to individual conferences and workshops.

Also in the audio-visual field, the Division worked with SRS in developing two TV public service spots—one on isolation of the elderly and one on nutrition. Some 350 TV stations have requested the spots to date.

Interest remained high during the year in a number of older publications, with large requests for "Are You Planning on Living the Rest of Your Life,"

a preretirement preparation booklet; "Handle Yourself With Care," a safety leaflet; and "The Fitness Challenge in the Later Years."

Aging magazine continued and expanded its service to the professional field of aging. Its present circulation is 16,471 copies, of which 7,971 are paid, and 8,500 are free.

Public inquiries are steadily increasing by mail and phone.

Through the year, the Information Division assisted other program divisions of AOA, particularly in publication of an increasing number of administrative papers providing advance looks at reports and results of AOA-funded research and demonstration programs (title IV), and in assisting with development of guidelines to the field and presentations for training sessions on the new area-wide program, the RSVP program, and use of social indicators.

The Division is beginning a newsletter designed to improve communications between and among central AOA staff, regional staff, State agencies on aging, and other Federal agencies in a time of developing news and materials.

The year saw a great increase in media interest in aging. Time, Life, the National Observer, the National Journal, the New York Times, Geriatrics, Harvest Years, the Gerontologist, the Red Cross Journal, the National Journal of Nutrition, the Wall Street Journal, Changing Times, and the Los Angeles Times Syndicate featured articles on aging for which the Information Division provided assistance and materials.

Background was also provided to Westinghouse's Urban America Division, as it prepared for production of its new film "When You Reach December." Much information is, of course, continuously provided to correspondents on a number of newspapers and syndicates throughout the country who are writing regular columns or series on aging.

Church Involvement in Aging

Early in 1970 AOA began exploration with religious denominations nationally on possible involvement of churches in community services for older Americans through technical assistance from AOA. It was agreed at a meeting of denominational representatives that a pilot project would be desirable. For various reasons the denominational people recommended that Indiana be the pilot State.

Simultaneously, the Indiana Commission on Aging was proposing a workshop on aging and the churches, and asking AOA assistance. The recommendation of the denominational group was conveyed to the commission. The possibility was discussed with the Indiana Council of Churches, which expressed interest. By joint agreement, AOA was invited to present the pilot program possibility to the annual clergy conference of the council of churches. The clergy agreed to participate.

It was then decided to see if the denominations not affiliated with the Indiana Council of Churches would join in a combined pilot program in the State. A statewide meeting was held after the cooperation of most denominations was assured. AOA was asked to develop a program guide which could be used by individual churches or by groups of churches working together. The final draft of the guidebook was the product of the AOA staff, denominational representatives, and the staff of the Indiana Commission on Aging. Publication was dependent on the availability of funds and the need.

During the year Indiana became eligible for funds under the Older Americans Act which added impetus to the project. For example, the Catholic diocese in the Evansville area found 70 parishes interested in the project. Protestant churches likewise rallied to the program. The sociology department of Evansville University agreed to join in the project. Planning was being directed toward a variety of church-based ways to serve older people.

At the December 1970 meeting of the Indiana Commission on Aging, the State council of churches reported the establishment of a regional plan which included clergy committees, regional conferences, and development of programs for older people.

White House Conference on Aging

During the year, AOA personnel worked closely with the staff of the White House Conference on Aging in preparing for the 1971 Conference. The Division of Older Americans Services (title III) enlisted the cooperation of the network of State and local offices in aging in planning and conducting the community

forums and other local and regional activities needed to make the Conference a success.

Time and again, it was necessary to call upon one or more members of the AOA staff for specialized advice or assistance. The location of most of the offices of the White House Conference staff near AOA offices facilitated communications and cooperation.

President Nixon in calling the White House Conference on Aging on October 6, 1969, used the phrase "develop a more adequate national policy for older Americans." John Martin, Commissioner on Aging and Special Assistant to the President for the Aging, as Director of the Conference, pledged that the Conference would work "toward a national policy on aging," and this has become the Conference theme and objective. The Conference has been structured to fulfill this objective.

During the early part of 1970, the broad plan for the Conference was developed by the staff assembled for Conference purposes, following the passage of the appropriation bill. The broad plan was for a 3-year effort, which was described in the Conference fact sheet issued early in 1970:

"* * * as a continuous process of growth, not as a single event. One of the important features of the new 1971 Conference format is the concept of a 3-year plan:

"THE PROLOG YEAR—1970

"This is the year when older Americans speak out on their needs as they see them: in forums, hearings, and meetings in thousands of communities across the Nation. Senior Citizens Month in May marked the official beginning. The theme for the month is the theme, appropriately, for the year itself: 'Older Americans Speak to the Nation—A Prolog to the White House Conference on Aging.'

"Most important of the year's events will be the older Americans White House forums to be held in communities and neighborhoods in every State during the third week in September.

"The ideas advanced and needs described in the White House forums will be forwarded to Washington along with information developed from other sources. Technical committees will draw on these materials to prepare background papers. The papers will provide a foundation from which the recommendations of the Conference year will be developed.

"THE CONFERENCE YEAR—1971

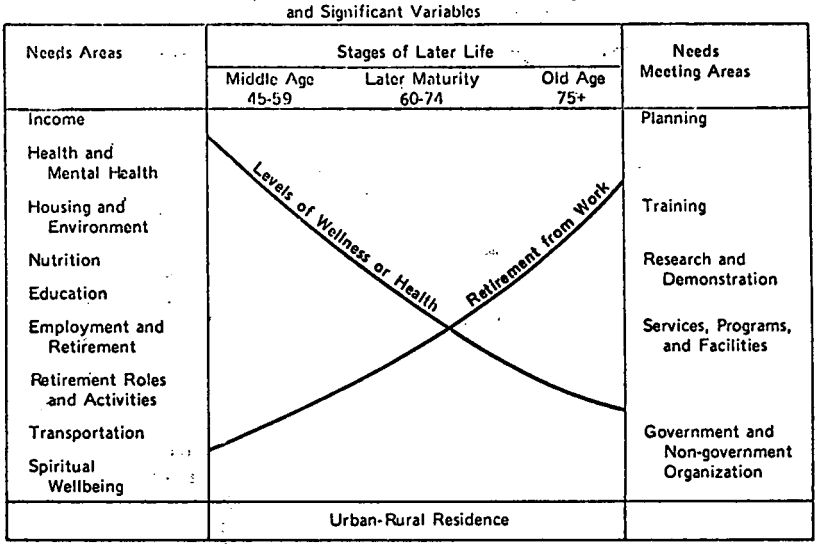
"This is the year when policy recommendations will be worked out: first in community and State White House conferences during the first half of 1971. National organizations also will develop recommendations. These community, State, and organization recommendations will be forwarded to the technical committees. New background papers will be drafted. The revised papers will provide the work base for the national White House Conference in November 1971. From it will come the final and 'precise recommendations' requested by the President for Federal, State, and local government action and private and voluntary action.

"THE POSTCONFERENCE YEAR—1972

"This is the year when follow through begins: a plan of action for the 1970's. If the goals of the Conference are achieved a national policy on aging will emerge from the deliberations of the conference year. A drive for a greater public awareness in and concern for the needs of older Americans will be intensified. It will be the time for action by Federal, State, and local governments; for a stronger commitment by national organizations serving older people, and for more involvement in their own behalf by older people themselves."

The staff also developed a concept of the Conference, which identified the principal participants—consumers of services (that is, older Americans), providers of service, and the specialists—delineated the principal needs areas and important needs-meeting mechanisms, identified stages of life, and highlighted such variables as wellness, retirement status, and urban-rural differences. This chart follows:

Schematic Representation of Needs and Needs Meeting Areas and Significant Variables



To acquaint all who were to be involved in the planning process, the Director in the early months of 1970 presented the program to the Secretary of Health, Education, and Welfare, to the White House and to the representatives of the National Association of State Units on Aging. He also advised Governors of the States, Members of Congress, and representatives of national older persons organizations of the general plans. Other Federal departments and agencies were apprised and invited to name Conference liaison representatives.

Concurrently, the steps toward implementation of the first-year plan to listen to older Americans and toward the organization of a planning board and technical committees were taken. The report of the former follows.

COMMUNITY AFFAIRS

The method adopted for listening to older Americans speaking was the Older Americans White House community forums. The materials developed for the forums described them in this way:

"WHAT IS AN OLDER AMERICANS WHITE HOUSE FORUM?

"Older Americans White House forums represent opportunities at the community level for older people to testify to or identify their needs, whatever these may be. The Older Americans White House forums are regarded as prologs to the community, State, and national White House Conferences on Aging to be held during 1971. The needs older people identify in the forums of September of 1970 will be reported for use in the development of recommendations by the White House Conferences.

"The forums provide a means for the free and open discussion of the needs older people report and the priorities they assign to them. By this means, the older persons participating in the Older Americans forums will provide the initial voice in the development of a national voice on aging.

"Briefly, the format of the Older Americans forums will consist of: an introductory plenary session; the administration of a questionnaire about the needs of older people; workshop discussion by the participants directed toward a panel of selected community representatives; a luncheon period; completion of the workshop discussion; and a final plenary session to summarize events, choose priorities in areas of concern to older people, and conclude the forum."

States were given assistance during the late spring and early summer on forum organization. Regional meetings were held to brief staff of State agencies on aging on the organization and conduct of forums, use of other manpower for

organization, and the essentials of reporting forum results. Later a self-guide was issued to assist local groups in forum organization since State staff was too limited in many cases to cope with the requests.

To permit older persons to register their opinions whether they spoke or not, a subjective questionnaire was developed and distributed. Evidence of the interest in the forums was the increase in State orders for questionnaires which went from an initial order of 750,000 to 1,200,000, and eventually some States printed their own, increasing the total to 1,700,000. Versions in both English and Spanish were provided. Tabulation had not been completed by the end of 1970.

As of December, the State agencies on aging reported that they had conducted more than 6,000 Older Americans White House forums. Most of these were held during the week of September 20–26; however, at the end of 1970 some States were continuing to hold forums as more communities asked to be involved in White House Conference activity.

White House forums were conducted in each of the 50 States, as well as in the several territories. Participating in these forums was a wide array of older persons, broadly representative of racial, ethnic, cultural, economic, and religious groups, and widely characteristic of the rural and urban areas. Also, the forums were attended by "listeners," who represented a cross section of providers of services, local, State, and national legislative figures, Government officials, and other community leaders.

The White House forums were of various sizes. Many were held on a neighborhood basis and were attended by small numbers of people. Others were conducted in larger areas, such as counties, legislative districts, or other regions corresponding to State planning districts.

The locale of individual forums was equally varied, with meetings being held in such places as senior centers, civic auditoriums, fraternal and service club buildings, churches and synagogues, individual homes, professional office suites, public housing projects, nursing homes, retirement villages, tribal houses on Indian reservations, schools, and many others. In at least one case, a forum was conducted by the older inmates of a State penitentiary.

An important part of the forum activity, encouraged in the guides, was local media coverage. Clippings sent in by communities and States, plus those from the clipping service, indicate broad coverage in newspapers of all sizes. Reports also indicate good radio and TV coverage, both commercial and educational. This was important, too, in acquainting the general public with the needs of older people and with the 1971 Conference.

NATIONAL ORGANIZATIONS

Just as communities and States were involved in the first year of the 3-year Conference plan, so were national organizations. Staff identified 285 national organizations, thought to have some interest in older people and their problems, who were invited to orientation meetings during July. Other organizations indicated an interest and the total invited to participate reached 367.

During the July orientation meetings, organizations were arbitrarily assigned to groupings for instructional purposes. These broad groupings were religious; business, consumer and labor; fraternal, service and social; professional; and community action. Meetings had previously been held with the national organizations of older persons and the scientific societies. In addition to giving the representatives the broad conference plan, organizations were invited to submit position papers for use of the technical committees, to identify leaders for involvement at the State level in Conference planning, and to assist in the organization of Older American White House community forums.

Emphasis during the orientation was given to the part national organizations could play in the Conference. In addition to being told they would have delegate representation, they were asked to name representatives to task forces. The statement given to national organizations describing how task forces would function follows:

THE CONFERENCE PROCESS

"Policy formulation will be the business of the Conference when the delegates from States and participating national organizations convene on or about November 28, 1971. Policy is built on recommendations. Recommendations will be developed by communities, States, and national organizations during the first 5 months of 1971. Recommendations will be based on background papers prepared under the guidance of technical committees composed of competent persons

assisted by governmental staff members and written by highly qualified individuals chosen for their expertise in the particular area.

"The technical committees are organized around nine needs areas: health, income, housing, nutrition, transportation, employment and retirement, education, roles and activities, and spiritual well-being; and five needs meeting mechanisms: planning, training, services and facilities, research and demonstration, and Government and non-Government organization. The latter as a group are interrelated to each of the nine needs as well as each being subject to general consideration. A background paper will be prepared by each of the 14 technical committees. Each paper will conclude with issues offered as a basis for discussion and policy recommendation.

"States are being asked to organize task forces for each needs area. Some communities will also use the task force approach. Using the issues developed by the technical committees, the States will develop recommendations. It is expected that all State-developed recommendations will be related to one or another of the needs areas covered by a task force and will be responsive to one of the identified issues. These recommendations will be collated by regions, thus furnishing the Conference with consolidated recommendations by needs areas.

"Just as State recommendations are being consolidated by regions into 10 reports for consideration by the technical committees, so it is essential that recommendations of groups of national organizations be consolidated. To accomplish this, it is necessary to ask the national organizations within each of the appropriate groups listed above (religious; professional; fraternal, service, social; business, consumer, labor; community action) to designate representatives for participation in the task forces for the needs areas. Since it is necessary to limit the size of the task forces, each organization is requested to name no more than two representatives and to designate first, second, and third preferences for each designee for assignment to task forces."

HOW THE TASK FORCE RECOMMENDATIONS WILL BE USED

Reports from the national organization task forces will be coordinated by the respective task force chairmen. The end product will then be nine national organization task force reports. These will be consolidated with the nine needs area reports resulting from the consolidation of the 10 regional reports, which will have been drawn from the reports of the States in each region.

Prior to the conference in November 1971 the delegates from national organizations and States will be assigned to work groups representing the 14 areas of concern (nine needs and five needs-meeting mechanisms). The delegates will receive the appropriate background papers prepared by the technical committees. These will, at that time, include the previously described consolidated recommendations from the national organizations and State conferences. This process will permit the delegates to use the recommendations in arriving at national policy proposals, the primary objective of the White House Conference on Aging.

It should be noted that the organizations were not offered any financial assistance to cover cost of task force participation. However, by late December, 451 task force representatives had been named. More were expected prior to a series of training sessions scheduled for early February 1971. Task force meetings were scheduled for 2-day sessions in early March 1971.

PLANNING BOARD

Various officials felt that the National Advisory Committee of 28 members called for in the joint resolution (Public Law 90–526) was too small to represent the many groups in the United States interested in aging. To accommodate the broader involvement a Planning Board was established. The primary component of the Planning Board was the Advisory Committee composed of distinguished older Americans who were recognized for prior contributions to American life, continuing participation in careers, or in second or third careers. The Honorable Arthur S. Flemming, Secretary of Health, Education, and Welfare at the time of the 1961 White House Conference on Aging, was designated as Chairman of the Advisory Committee and Planning Board. Vice Chairmen and members of the Advisory Committee are: Milton S. Eisenhower, Inabel B. Lindsay, and the Honorable Earl G. Warren.

Other members are: Hon. Bertha Adkins, Hon. Frances P. Bolton, Walter L. Bond, Gen. Lucius DuB. Clay, Consuelo Castilla de Bonzo, Louella C. Dirksen, Edward K. (Duke) Ellington, Rabbi Louis Finkelstein, Gen. Alfred M. Gruen-

ther, Hon. Cecil M. Harden, A. Baird Hastings, Robert J. Havighurst, Ailee Henry, Laura B. McCoy, George Meany, Melvin N. Newquist, M.D., Frell Owl, Ollie E. Randall, Lawrence Cardinal J. Shehan, Hon. Mary E. Switzer, Hon. Charles P. Taft, Bernard S. Van Rensselaer, Thomas G. Walters, and Paul D. White, M.D.

Other components of the Planning Board are:

An ad hoc Council of National Organizations of older persons composed of representatives of the several membership organizations composed of retirees;

The Older Americans Advisory Committee, which advises the Commissioner on the implementation of the Older Americans Act, and in this position affords coordination with the ongoing AOA program;

A liaison committee appointed by the National Association of State Units on Aging representative of the State aging programs in each of the 10 HEW regions;

Representative members of major membership youth organizations with the responsibility of relating youth with age; and

Chairmen of the 14 technical committees, in order to relate the formulation of issues to the conference plans.

The Planning Board met in mid-October to review staff plans and to advise the Commissioner/Director on conference policy and directions. Additional meetings are planned early in 1971 to establish the conference format and details of conference procedure.

TECHNICAL COMMITTEES

To launch the national organization task forces and community and State White House conferences in the process of developing policy proposals, technical committees charged with the formulation of issues were appointed, as authorized. In preparation for the consideration of issues, outstanding authorities in various aspects of aging were commissioned under a grant to Brandeis University to prepare background papers covering the nine needs and five needs-meeting areas. The papers are in five parts which are: "a discussion of the need or needs-meeting area, well-established long-range goals, existing knowledge in the specific area, gaps and shortcomings in the area, and suggested issues."

Technical committees have met with the authors, made suggestions covering the first four sections and then have formulated issues as discussion areas for meetings of national organization task forces and community and State conferences. As the guide for community and State White House conference points out, discussants are not limited to suggested issues. At any point new issues may be introduced and policy proposals formulated from these issues. Technical committee issues are expected to cover major considerations, but are not delimiting.

Chairman of the technical committees are: Dr. Roger Murray, Income; Noverre Musson, Housing; Dr. Edward J. Lorenze, Health; Dr. Donald M. Watkin, Nutrition; A. Webb Hale, Employment-Retirement; Dr. Walter C. McKain, Roles and Activities; Thomas C. Morrill, Transportation; Dr. John W. McConnel, Education; Hess T. Sears, Spiritual Well-Being; George E. Wyman, Services; William Rutherford, Planning; Dr. Alfred E. Lawton, Research; Dr. George G. Reader, Training; and Dr. W. Fred Cottrell, Government and Non-Government Organizations.

Authors of the background papers are: Dr. Yung-Ping Chen, Income; Dr. Austin B. Chinn, Health (Physical); Ira S. Robbins, Housing; Dr. E. Neige Todhunter, Nutrition; Dr. Howard Y. McClusky, Education; Dr. Irvin Sobel, Employment; Dr. James H. Schulz, Retirement; Dr. Gordon F. Streib, Roles; Joseph S. Revis, Transportation; Dr. David O. Moberg, Spiritual Well-Being; Dr. Robert Binstock, Planning; Dr. James E. Birren, Training; Dr. Alexander Simon, Health (Mental); Dr. George Maddox, Jr., Behavioral/Social Science Research; Dr. Edwin L. Bierman, Biological/Medical Research; Dr. Robert Morris, Services; and Dr. W. Fred Cottrell, Government and Non-Government Organizations.

Supplementing each technical committee is a professional secretariat recruited from governmental personnel with expertise in one of the needs and needs-meeting areas. Each secretariat is advisory and will assist the committee in its deliberations.

After the national organization task forces and the State conferences have completed the formulation of policy proposals in the spring, it is anticipated that the technical committees, assisted by the secretariats, will collate the pro-

posals for use of the national conference delegates. After the conference, the committees will probably supervise the compilation of the reports on the needs and needs-meeting subject matter areas.

DELEGATES

Final determination of delegate sources and numbers was still under consideration by the planning board at the year's end. However, preliminary discussion indicated States and national organizations would be represented. In the case of States the planning board had set a maximum delegation size of 100 and a minimum of 14 with the percentage of population over 65 as the base for calculation. A total of 3,000 was considered to be the delegate limit.

A formula was also being developed to allocate funds to the States for payment of delegate expenses. Consideration was being given to distances to be traveled in order to insure representation of substantial numbers of older persons who would not be able to pay travel costs. It is expected that criteria for delegate selection will follow the suggestion for communities and State conferences which are:

	Percent
Middle-aged and older people	45
Providers of services	35
Specialists in aging	10
Decisionmakers	5
Youth	5

Within these groups it will be essential, of course, to recruit participants who are knowledgeable or especially interested in each of the subject-matter areas to which the conference will be addressed.

In view of the effort to recognize the needs of older people at each of the later life stages, it is suggested that the age distribution of middle-aged and older people be spread approximately equally over the three age periods 45–59, 60–74, and 75 and over.

REGIONAL HEARINGS

One of the objectives of the conference is nationwide involvement. To this end, plans to involve communities, States, national organizations, and regions have been developed so that all those involved in aging would become part of the conference process. Regional involvement to date has been in concert with States and those national organizations with similar regional structures.

Early in 1971 the conference will move to the regional level through a series of hearings. The Federal regional councils have indicated support. The regional Directors for HEW have been given the primary responsibility for coordinating the hearing programs. It is anticipated that the subjects of the hearings will be one or more of the areas of need on which the conference is based. Information gathered in the hearings will be used to supplement the background papers for which the technical committees are responsible.

INTERAGENCY COOPERATION

During 1970, as in prior years, the Administration on Aging was alert to opportunities to coordinate its efforts with activities in aging of other Federal departments and agencies. The following are examples of such interagency cooperation:

1. After conferences with Administrator Robert D. Moran of the Wage and Hour Division and others in that agency, a memorandum of understanding was signed by Commissioner Martin and Administrator Moran, in which these two officials agreed to coordinate their efforts to implement the Age Discrimination in Employment Act of 1967.

2. The Administration on Aging worked with other representatives of the Department of Labor and with representatives of the Office of Economic Opportunity and the Office of Management and Budget on the development of Federal policy concerning community service programs which focus on new social roles for the elderly.

3. There were a series of discussions between the Administration on Aging, the Department of Agriculture, and the Office of Economic Opportunity in an effort to formulate a national nutrition program for the elderly. As the year ended, AOA was actively engaged with the Office of Economic Opportunity, the Office of Management and Budget, the Community Services Administration, and

other HEW components, in developing plans for demonstrations of nutrition services as part of a comprehensive social services delivery network.

(Attached as attachment 1, is a more detailed discussion of these efforts.)

4. A number of meetings were held between AOA, CSA, and the Social Security Administration on providing information and referral services to older people through the existing nationwide network of Social Security district offices.

5. Commissioner Martin cooperated with Commissioner Howard Newman of the Medical Services Administration in initiating a series of proposals to the Secretary which resulted in the establishment of an Interagency Committee on Long-Term Care. This group is comprised of representatives of AOA, MSA, CSA, Assistance Payments Administration, and the Health Services and Mental Health Administration. It is developing recommendations for both a short- and a long-range strategy for the department to undertake in correcting abuses and developing alternative means of meeting the long-term care needs of frail and ill older people.

6. Serving as a clearinghouse of information on the Nation's aged, as required by the Older Americans Act, AOA filled a number of requests from other Federal departments and agencies for statistics, consultation, and other information.

7. AOA jointly funded a research project with the Departments of Transportation and Housing and Urban Development whereby a national workshop on transportation and aging was convened. It brought together for the first time members of the transportation and gerontological communities. A publication outlining the recommendations of the workshop has been released, and a monograph on "Transportation and Aging," based on the proceedings, was being printed as 1970 ended. In addition, one other transportation research project was jointly funded with each of those departments, making a total of three such projects jointly funded and sponsored during 1970.

8. The title IV staff and the staff of the Urban Mass Transit Agency conferred periodically in an effort to develop guidelines for the development of additional research and demonstration projects for the implementation of the Biaggi amendment to the Mass Transit Act of 1970.

Evaluation Activities

The Administration on Aging has undertaken several specific studies during 1970 dealing with the assessment and evaluation of its programs.

A social indicator system for the aging is being developed under grant. The objective is to put into effect a system which could measure the status of the elderly population with respect to such factors as income, housing, health, etc. The application of these indicators will permit the assessment of a program's impact on the elderly population by providing a before and after picture.

A second evaluation project currently in progress is evaluation of community programs under the title III State grant program which will measure that program's success in meeting its objectives. The design is nearly complete and present plans envision its implementation during the coming year.

Another project, both an evaluation and a design, is assessing the current information clearinghouse function of the Administration on Aging to document its nature and extent and then make recommendations on a system which might be adopted to more fully implement this specific responsibility under title II of the Older American's Act of 1965, as amended.

[Attachment 1]

Nutrition Discussions

During the early months of the year a series of discussions were held between the Administration on Aging, Department of Agriculture, and the Office of Economic Opportunity to try to formulate the scope of a national nutrition program for the elderly. In the midst of these deliberations, Congressman Pepper during May introduced H.R. 17763, a proposed amendment to the Older Americans Act that would establish a national nutritional program for the elderly. Subsequent discussions were held between the Administration on Aging, Department of Agriculture, the Office of Economic Opportunity, the Office of Management and Budgeting, and several organizational components of the Department of Health, Education, and Welfare, to further develop an administration proposal for such a national nutrition program. The resulting position presented by Com-

missioner Martin in testimony before the Select Subcommittee on Education of the House Committee on Education and Labor, on September 24, 1970, consisted of four elements:

1. The introduction of amendments to the proposed title XX of the Social Security Act to permit financing of the program from a large and flexible source;

2. The conduct of a major fight of the provision of nutrition services to the elderly as an integral part of a more comprehensive social services network;

3. An increase in the advisability of convenient places in which to deliver nutrition services to the elderly; and

4. The provision of technical assistance to States and communities to facilitate the development and local delivery of nutrition service for older persons.

As the year ended, AOA was actively engaged with OEO, OMB, the Community Services Administration, and other HEW components, in developing the preparations and plans for the major demonstration of the provision of nutrition services as part of a comprehensive social services delivery network.

ITEM 2: ATOMIC ENERGY COMMISSION

U.S. Atomic Energy Commission,
Washington, D.C., January 5, 1971.

Dear Senator Williams: It is a pleasure to have this opportunity to provide information on the Atomic Energy Commission's research program on aging for inclusion in a report by the Special Committee on Aging to be entitled "Developments in Aging—1970."

In fiscal year 1970 the Atomic Energy Commission spent $5.6 million for research related to aging, as a part of its overall program in radiation biology. The comparable allocation in fiscal year 1971 is approximately $5.3 million.

During the past year two major conferences have been held under the auspices of the Atomic Energy Commission on the problem of the mechanism(s) by which high, but sublethal exposures to ionizing radiation may lead to shortening of the lifespan. It is not yet established that irradiation results in the same pattern of tissue changes seen in normal aging, but the fibrotic changes in irradiated tissues simulate those seen in unirradiated aged people and experimental animals. Also, ionizing radiation can be carcinogenic in both man and animals and the resulting tumors are indistinguishable from those occurring spontaneously.

In the latter instance, induction of a malignant cancer generally leads to death sooner than otherwise would occur, but a very fundamental question is whether radiation has merely accelerated the appearance of a biomedical process, such as cancer, that would have occurred later during the lifespan. In short, how does irradiation modify the pattern of degenerative and other diseases making up the current statistics on causes of death versus chronologic age? These and related questions were examined at length at the two conferences mentioned above. One held at Oak Ridge National Laboratory on April 6–9, 1970, was entitled "Cellular and Macromolecular Aspects of Aging"; the other at Argonne National Laboratory on December 7–9, 1970, was "The Estimation of Low Level Radiation Effects in Human Populations." Papers and discussion from both conferences are in the process of being published. Their impact will be felt during the next few years in terms of choices of problems to be investigated, in the formulation of new hypotheses, and in the construction of experiments and models to test them.

Investigations of aging in man of necessity have employed the techniques of (1) examining a range of biomedical characteristics exhibited by cross-sectional groups of people of given chronological ages; and (2) following biomedical changes and altered physiologic functions thought to be causally related to aging in relatively small numbers of people on a long-term basis. The Atomic Energy Commission has supported two studies of the latter type for some years, but with the difference that large numbers of persons are involved. Although both these studies must be continued for a number of years in order to obtain maximal yield, they are now entering a stage where definitive information on aging may be forthcoming.

One study, that of the Japanese populations of Hiroshima and Nagasaki, is carried out by the Atomic Bomb Casualty Commission and is jointly supported by the Governments of the United States and Japan. About 112,000 Japanese citizens in these cities are being observed for longevity and morbidity/morality; slightly more than 50,000 of these people were exposed to some degree of ionizing radiation by the weapon bursts of 1945. The selfless spirit of cooperation of these Japanese citizens cannot be praised too highly. Twenty thousand people from this population have been receiving thorough biennial medical examinations for the purpose of detecting incipient diseases and otherwise evaluating their health status. Of these 20,000 persons, 10,000 were exposed to radiation and their doses are known; the other half are controls matched as to age and sex who were outside the cities or were beyond range of the radiation perimeter. From observation of these two populations with their built-in control groups may emerge answers to questions such as: (1) Does ionizing radiation affect the lifespan of persons living under conventional circumstances? If so, how much is the lifespan decreased on the average per unit of exposure? (2) What biomedical changes can be observed over the long term in such a major population unit with respect to chronological aging? Are these changes different in the exposed versus nonexposed? Are patterns of morbidity/mortality to be found in the exposed which are absent in the controls? (3) Are there patterns of aging and/or morbidity/morality characteristic of the Japanese vis-a-vis other nationalities?

This study is now entering its 26th year and as the youngest members of the group are 26, biomedical conditions associated with aging or intercurrent death should appear with increasing frequency. Thus far, only an increased mortality from leukemic disorders and in morbidity of thyroid cancers can be documented statistically as being related to irradiation. In other aspects the exposed and internal control groups appear similar. Developments over the next few years will be watched with great interest.

The second, large, long-term, epidemiologic study of a human population is one designed to investigate whether employment in the nuclear energy industry is associated with medical conditions or patterns of illness not seen with equal frequency in appropriate control populations. At this time the occupational records of some 175,000 current and former workers are being readied for comparison against the Social Security Administration's Old Age Surivors and Insurance Division's data banks. When the records of all workers and controls have been compiled, the number may be in the neighborhood of 500,000. No predictions can be made at this time as to the central question, but at the very least this study will create a well-documented body of data on the aging of men from the standpoint of occupational medicine. Indeed this program is perhaps the largest, most comprehensive cohort study ever undertaken in the field of occupational medicine.

Somewhat more than 4,500 beagle dogs are employed in five major experiments which are investigating the long-term effects of a range of doses of ionizing radiations arising either from outside the body or from radioactive isotopes that may have deposited in the tissues for a variety of reasons. For example, parts of two experiments simulate in the beagle the conditions which led to the chronic radium poisoning of the watch dial painters in the 1920's; similarly, the long-term effects, if any, of exposures to the radioisotopes associated with fallout and employment in industries which handle radioactive substances are being studied, etc. From these experiments data are emerging which suggest what might be the long-term effects of large exposures in man as well as the exposure levels compatible with a normal lifespan. Obviously, what constitutes a normal lifespan in the beagle both as to chronological age and pattern of causes of death continues to be carefully analyzed in the nonexposed control animals.

The beagles regularly live to the age of 15 to 16 years under confined conditions if given proper care. The record of how this can be accomplished together with detailed anatomic and physiologic information on the beagle has been published in a volume edited by A. C. Andersen, "The Beagle as an Experimental Dog." Iowa State University Press, Ames, 1970, 616 pages. This book should certify the beagle as the experimental animal of choice for aging experiments which require lifespans approaching those for man.

We hope this information will be of use to the Committee.

Cordially,

GLENN T. SEABORG, *Chairman.*

ITEM 3: DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

THE SECRETARY OF HOUSING AND URBAN DEVELOPMENT,
Washington, D.C., January 22, 1971.

DEAR SENATOR WILLIAMS: There is enclosed a report on the 1970 activities of this Department with respect to the several housing programs for the elderly, and related facilities, in response to your request of November 25, 1970.

This statement and statistical data are for publication in the annual report of the Senate Special Committee on Aging, entitled "Developments in Aging—1970."

Let us know if we can be of further assistance.

Sincerely,

GEORGE ROMNEY.

[Enclosure]

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT—1970 HIGHLIGHTS

INTRODUCTION

The Department of Housing and Urban Development now administers 21 different programs which provide some form of assistance (directly or indirectly) to our elderly population. Housing programs directed specifically and exclusively to the elderly population (such as low-rent public housing projects designed for the elderly and nonprofit and limited-profit sponsored housing under section 202) have been in operation for more than a decade. These latter programs account for the sharp rise in federally subsidized independent living accommodations designed for the elderly, from 1,100 units in 1960 to 180,000 in 1970.

"Designed for the elderly" tells only part of the story, for the elderly have occupied low-rent public housing from its inception, and their participation in the program, before the provision of housing specifically designed for the elderly, had reached 77,000 general purpose units in 1960, and 156,000 by 1970. Thus, by mid-1970, federally assisted programs have produced over 336,000 subsidized independent living accommodations occupied by the elderly.

The steady rise observed in the number of general purpose low-rent public housing units occupied by elderly households probably will continue as a result of normal operations in both tenant intake and the aging process. At the same time, the present pipeline of units under construction, awaiting construction, and in applications awaiting approval indicate a continued high rate of participation by the elderly, in spite of the phasing out of the section 202 program, which is a direct loan program being converted to an interest subsidy program under section 236.

The older population also benefited from significant progress in 1970 in HUD programs not specifically identified as for the elderly. Recognition of their particular needs due to static and limited incomes was most starkly revealed in the model cities program. The aged population in these depressed neighborhoods ranged from 10 percent of the areas' population to 50 percent in some cities. Special programs for the senior citizens clearly were indicated and HUD instituted a series of actions to meet these needs.

HUD small town, new communities, and breakthrough also focused attention on the particular requirements of the elderly as a normal part of the general population in these emerging programs. About 60 percent of home rehabilitation grants in urban renewal and code enforcement areas continued in 1970 to be made to couples or individual homeowners aged 62 or over.

Interagency and cross-disciplinary teams have worked together in 1970 to assure services that would result not only in improved shelter but, so far as possible, a total living environment and the services needed by the elderly to sustain their independence and freedom from institutionalization. Programs on nutrition, education, health maintenance, transportation, and home aids have marked the year's effort to bring services within housing complexes or within easy access of the residents. Services emanating from housing centers have stressed the need for a neighborhood approach rather than community space and services restricted to the fortunate few in housing developments—thus housing becomes a community resource for the older population.

HUD health-related programs also increased in number in the past year. The FHA section 232 nursing home beds under insurance increased from 52,439 at December 31, 1968, to 70,739 at August 31, 1970, with another 12,738 beds committed but not yet insured. A large percentage of the occupants were elderly.

The first year of the intermediate care facilities program saw the completion of HUD–HEW criteria for construction and operation.

HUD participated in an increasing number of conferences, seminars, and university gerontological center activities.

MODEL CITIES PROGRAM FOR THE ELDERLY

Model cities program is of special significance to older persons because it advocates a comprehensive approach to the problems of the model neighborood. It does not present a solution only to health needs, or housing needs, or recreation needs, but to all of these needs as they relate to one another. This kind of approach is vitally important to older persons who, more than any other residents of depressed, low-income areas, remain neglected by the many fragmented and frequently uncoordinated program efforts aimed at improving the various conditions in their neighborhoods. Furthermore, model cities can give the elderly themselves a voice on determining the solutions to their problems. With these considerations in mind, model cities has attempted to assist city demonstration agencies (CDA's) in involving older persons in all stages of program planning and development.

Early analysis by cities involved in the model cities program indicated a heavy concentration of older persons in model neighborhoods. In virtually all cases, the elderly population of the model neighborhood exceeds that of the city and county and is often two to three times as large. Although up-to-date statistics are limited, those which are available indicate that percentages of older persons in model neighborhoods range from 10 percent of the population to nearly 50 percent of the population. A disproportionately large number of model neighborhood residents receive old-age assistance benefits and the degree of poverty among the elderly is startling. One city which recently completed a neighborhood survey indicated, for example, that one-fifth of their model neighborhood population is elderly and, of that, 93 percent have incomes below $3,500 per year, while 50 percent have incomes below $1,800. The same city estimates that 70 percent of its elderly population lives in poor to substandard housing. Statistics from other cities frequently place the average income of elderly persons at or below the poverty level. CDA problem analyses indicate that the elderly suffer not only because their income is low, but because it is fixed and does not permit them to cope with rapidly rising costs of living.

In order of importance, CDA's generally listed the major problems confronting the elderly as these: Housing, health and medical care, inadequate income, transportation, and isolation from the community in general.

These are the program areas with which CDA projects have most frequently attempted to deal. Many CDA's, however, in the course of devising programs for older persons indicated that the resources available to them were inadequate to meet the needs of older persons. Model cities, Washington, has, therefore, moved to increase at the Federal level resources and expertise which can be made available to local programs. Model cities has coordinated its efforts in the field of aging with the Administration on Aging/HEW and with the Office of Special Programs/OEO. Model cities has also worked with both of the above agencies to stimulate their interest in model cities, and their support, both financial and technical, for model cities projects.

The Administration on Aging has responded to these requests in several ways. Utilizing AOA funds earmarked for model cities, AOA gave a grant to the Syracuse University School of Social Work last year to devise guidelines for CDA's to use in involving the elderly in their programs. To date, this contract has produced two conferences and a draft series of guidelines. The first conference, held in Seattle, Wash., in January 1970, brought together CDA staffs and elderly residents of several model neighborhoods to discuss how model cities could best serve the needs of older persons and what kinds of general guidelines would be most useful to both residents and to CDA's. Following this meeting, a series of five documents was produced. These documents were reviewed in September 1970 by New York State CDA representatives, regional and Federal HUD/MC and HEW/AOA staff, and by the contract staff from Syracuse University. The conference indicated that some basic revisions were in order, and after these are made, the documents will be ready for distribution about February 1, 1971. AOA also earmarked about $1.2 million this year for programs in model neighborhoods.

In addition, model cities and the Administration on Aging jointly entered into a contract with the National Council on the Aging on July 1, 1970. This contract is currently providing technical assistance in programing for older persons to

21 cities (40 cities requested such aid) and will also provide a series of regional workshops on the subject. This workshop will utilize the guidelines now being prepared by Syracuse and will be held in cooperation with regional and State AOA staff.

The direct technical assistance rendered by NCOA will cover the spectrum of elderly programing: Organization of older persons to facilitate their involvement in the program, reorganization of existing groups of older persons to make them more responsive to and representative of residents of the model neighborhood, evaluation of existing programs, assistance in implementing programs which have been funded, assistance in locating staff and more specialized consultants, assistance in contract negotiation for local projects, and so forth. The application procedures for the technical assistance require a letter of concurrence and support for the request from an already existing organization of older persons. The contractor will, therefore, assist in coordinating resources which already exist, and will not duplicate services or resources.

Even prior to the letting of the contract and the grant discussed above, however, many CDA's had identified the need for programs for older persons and had included them in their comprehensive plan. At the present time, 59 cities (of a total of 142 which have submitted CCDP's) have included an elderly component utilizing supplemental funds. The cities have expended approximately $6.1 million in funds for such programs. Of this amount, $3,611,968 are model cities supplemental funds. The remaining $2,477,119 were contributed by city, State, and private sources. (This figure also includes a part of the Administration on Aging/ State commission on aging earmarked for model cities.)

Approximately half of the programs which have been submitted are now operational, with the remainder to begin implementation in the immediate future. The most common area of programing is recreation, and recreational activities are often housed in a "senior center" which offers other services as well. Health services are also prevalent as are nutrition programs, most often found in the form of a "meals on wheels" program.

Some CDA's have designed more innovative programs aimed at utilizing existing services and resources but making them more relevant and responsive to the needs of the elderly. A CDA in upstate New York, for example, has proposed a supervised living arrangement in a high-rise apartment complex for the elderly, which is located in the model neighborhood. The program would provide 24-hour supervision and homemaking assistance and would alleviate the problems traditionally suffered by elderly residents of public housing who are periodically unable to care for themselves.

A program in Georgia has redesigned a traditional meals on wheels program and subcontracted food preparation to a hospital's dietetic division. This permits meals on wheels to service older persons with special dietetic needs in their homes and at a low cost.

Several CDA's have used elderly program components to provide job opportunities for older model neighborhood residents, either as drivers for meals on wheels, as babysitters or teachers in day-care centers, as outreach workers or as part-time handyman workers.

Another innovative program which has been implemented is a day-care center for the elderly. Located in a public housing project, the program provides companionship, limited medical services, hot meals, and therapy for otherwise homebound elderly.

Boston, Mass., operates a very successful and extremely effective legislative advocacy program for older persons. Funded by model cities, OEO, AOA, and the State of Massachusetts, the Boston program for the elderly also provides for senior activity centers, home aide service, and health services and education. The legal project, however, has made the most obvious impact by lobbying efforts which resulted in the creation of the Massachusetts Department of the Elderly. The program in Boston is operated by an organization of older persons, the Boston Council of Elders.

Model cities is hopeful that the technical assistance contract with NCOA will stimulate the interest of more CDA's in innovative programs for older people. Funds are budgeted to extend the contract for another year to assure both wide coverage and impact and more comprehensive programing for older model neighborhood residents in the future.

Research on the transportation needs of the elderly population was included in studies undertaken in 1970. These studies were jointly funded in cooperation with the Department of Health, Education, and Welfare and with the Department of Transportation and focused on the mobility patterns of the older population. A 2-day workshop on early findings was held in May 1970. Another study, funded by HEW and HUD, covered the selection of tenants for housing for the elderly and handicapped and the services required to permit this group to live independently. In addition, formulation of a study on the effectiveness of current housing programs for the elderly should be ready for activation early in 1971.

Nashville Study on Transportation Needs of the Elderly

Fisk University, Nashville, Tenn., has undertaken a 3-year study beginning in 1969 to identify mobility patterns, life styles, and transportation needs of aging persons in the Nashville metropolitan area. Project results will be useful to transportation, housing, urban development, and social planners in providing balanced programs. The study is specifically designed to yield data which can be used effectively in the overall planning of the delivery of services and facilities required to meet the needs of the elderly in the model city area. The study will supplement the findings and recommendations of the interdisciplinary workshop on transportation and the aging, sponsored jointly by HUD, HEW, DOT and the report of the Senate Special Committee on Aging. The first year preliminary interviews of 300 elderly are completed. The study should be completed by July 1972.

Preliminary findings affecting transportation services include: (1) The majority of the elderly are capable of going out of the domicile alone; a significant minority go out very little; (2) the elderly would like to make more trips to attend meetings and church, senior centers, or for the purpose of simply "taking a trip"; (3) residents in general and older persons in particular in transitional areas need transportation services to a greater extent than those in other areas because stores are being closed down and facilities are being moved to another section of the city; (4) a "companion" is a central link in the transportation network of many older persons—for assistance in mounting buses and carrying packages and/or simply for company in long-distance trips; (5) the elderly with low income tend to have smaller behavioral maps and depend more on companions in tripmaking than those with higher incomes if certain variables are controlled; the desired independence in movement is achieved by those who can afford the type of transportation they need (e.g. taxis).

Interdisciplinary Workshop on Transportation Needs of the Aging

This workshop, jointly sponsored by HUD, DOT, and HEW was held May 25 and 26, 1970, to disseminate and utilize research findings related to transportation, environmental problems, habits, and needs of the Nation's elderly population to alleviate the transportation problems of the elderly.

Workshop proceedings have been prepared by the Brooklyn Polytechnic Institute and the Administration on Aging, HEW, for publication. The Senate Committee on Aging is using the workshop material plus other sources to prepare a report on the urgency of the problems and needed actions.

The May 25 Congressional Record includes remarks by Senator Harrison Williams, where he commends HUD, HEW, and DOT for their cooperative efforts in sponsoring a workshop on transportation and the elderly.

A Demonstration in Housing Severely Handicapped Elderly in Public Housing

The Hussey Hospital, Fall River, Mass., in cooperation with the Fall River Housing Authority contracted with HUD in May 1970, to study and assist a program under which elderly individuals more severely handicapped than those usually able to reside in public housing projects will be housed. The objective of the program is to develop, test, and evaluate an approach which would help local housing authorities determine what kinds of handicapped individuals might be housed and how their needs might be met within the resources available to local housing authorities (LHA's).

The significance of this program lies in the fact that the handicapped elderly have a tremendous need for low-cost housing and sufficient guidelines to LHA's as well as private sponsors are not available. The study will be completed in May 1972.

Operation Breakthrough

The special needs of the elderly population have not been overlooked in HUD's breakthrough program which is essentially directed toward the development and demonstration of technology that will result in more quickly and effectively increasing the housing inventory. In order to provide performance criteria to private housing system producers involved in Operation Breakthrough, HUD contracted with the National Bureau of Standards to provide design guidelines aimed at reducing home accidents, meeting the special needs of the elderly and minimizing the possibility of criminal activity. The need for criteria regarding home safety is apparent as accidents in the home result in approximately 29,000 fatalities annually and a single year injury rate of 4 to 21 million, as determined by the respective definition of "injury" by the National Safety Council or the Public Health Service. These criteria are being used as a design guide by breakthrough producers proposing to market housing for the elderly.

In 1970 all nine of the breakthrough sites broke ground. Housing units specifically designed for the elderly will be available on the sites. Of the approximate total of 2,800 housing units, about 1,700 are assisted; about 200 are public housing for the elderly, and 1,500 are supported by the 236 and 235 FHA programs, a limited number of which will be available for the elderly, but not on an assigned basis. The approximate 200 units are proposed for a 13-story high-rise apartment building for the elderly on the Memphis site. One-half of the units will be efficiencies; the remainder, one-bedroom. The site, which will contain a total of about 465 units in a mixture of building types, was also designed with convenient access to public transportation and pedestrian access to a large medical complex, recreational activities and shopping facilities. On other sites, for example, open space areas have been designed specifically for use by the elderly, e.g., Jersey City.

Additional research is being supported to study the causes of home accidents and remedial measures for prevention and to develop standards for securing dwellings against crime. Both are important factors relating to the elderly. The research findings are being implemented in the design criteria used by the breakthrough producers.

The Brown Engineering Co. has completed phase I of a three-phase technical study on the causes of home accidents, the study to be completed in 1971. The remedial measures of home accident prevention will be used in HUD design and construction standards. A manual also will be produced as a design guide to developers and manufacturers. The newly developed standards will be tested in experimental housing both inside the home and on the lot outside.

Since a large number of home accidents are experienced by the population group 65 years of age and over this study will be particularly responsive to their needs. In addition, the findings will aid elderly homeowners to remove identified accident hazards which in turn should permit many to remain safely and happily in their homes for many years. Such data will be used in preretirement counseling sessions on housing considerations.

HUD also executed a contract in 1970 with the Law Enforcement Assistance Administration of the Department of Justice to develop data on which to base standards for securing dwellings against crime, a subject of immediate interest to the older population. This study will attempt to accurately determine the characteristics and patterns of crime committed on residential property in urban and suburban areas by unlawful intruders and to bring about improvements in dwelling security systems and materials. Completion of the study is expected in September 1971.

METROPOLITAN PLANNING AND DEVELOPMENT—RESOURCES FOR THE ELDERLY

The Office of Metropolitan Planning and Development, HUD, embraces a series of programs designed to improve the quality of life for persons of all ages. Several of these programs have particular significance for the older population, the majority of whom reside in metropolitan areas or small towns. Thus, programs for neighborhood facilities, open space land (including small city parks), small town assistance, and new community assistance reflect concern for the elderly population and their special need for environmental improvements.

Neighborhood facilities program

The neighborhood facilities program provides two-thirds grants (three-quarters in Economic Development Administration (EDA)-designated redevelopment areas) to local public bodies to assist in the construction of multiservice neighborhood centers for low-income neighborhoods. Funds cover the acquisition of land, demolition, new construction, rehabilitation of existing structures, landscaping, architectural/engineering fees, parking lots and other minor outdoor development. Funds for the operation of services and activities that will take place in the facility must be obtained from sources other than HUD. Grants are made only to public bodies; however, nonprofit organizations having the legal, financial and technical capacity may subcontract with the public body to own and/or operate the facility.

The facility must offer a wide range of health, welfare, educational (remedial, noncurricular), social, recreational, and other similar antipoverty type community services. Facilities must serve all age, race, sex, ethnic, etc. groups in the neighborhood; however, under certain circumstances a facility may serve a predominantly senior citizens group, provided that there is close coordination with other groups and institutions serving the neighborhood and that these other institutions adequately serve other age groups in the area.

As of June 30, 1970, 440 neighborhood facilities projects had been approved by HUD. Of these, 49 percent offer some type of service or activity designed specifically for senior citizens. (In projects approved during the first half of fiscal year 1971, 54 percent included senior citizens activities.) Three centers which are predominantly senior citizen in orientation are: the Astor Dowdy Neighborhood Center in High Point, N.C.; the Dayton Senior Citizens Center in Dayton, Ohio; and the South Shore Community Center in Miami Beach, Fla.

The Astor Dowdy Center serves a model city neighborhood of some 14,000 residents, 60 percent of whom earn less than $3,000 annually and 70 percent of whom are black. The facility opened in August 1968 and is operated by the Economic Opportunity Council. The center occupies 6,000 square feet of space, was built in conjunction with a low-income housing project and offers such services as remedial education, employment counseling, health, welfare and voluntary community organization services. The center will be closely coordinated with another neighborhood facility, the Southside Community Center, to be built in the near future.

The Dayton neighborhood facility is operated by a nonprofit organization, Senior Citizens Center, Inc., and serves a population of 7,000, 50 percent of whom earn less than $3,000 annually and 50 percent of whom are black. The center consists of 25,000 square feet, began operation in June 1969, and offers such services as vocational counseling, health, welfare, voluntary community organization services, legal aid, recreation, and other senior citizens activities.

The South Shore Community Center in Miami Beach will serve a predominantly senior citizen population of 16,000, 60 percent of whom earn less than $3,000 annually. The facility will offer a number of health, welfare, remedial education, social, and recreational services. A grant allocation was approved in June 1969.

The elderly in new communities

All new community projects for which Federal commitments have been offered under title IV, the New Communities Act of 1968, and all projects for which the Office of New Communities Development has invited applications are designed to provide a better quality of life for persons of all ages and income categories. Neither the elderly nor low-income families and persons will be segregated into isolated neighborhoods in these new communities, which will be marked by a variety in generations, outlook, income, professions, trades, skills, racial and ethnic backgrounds, and interests. Facilities and amenities designed to serve the entire community will be more adaptable to the special needs of the elderly than a typical suburban community and, in the view of this, may offer broader opportunity for age mingling to the elderly than communities designed only for retirement living.

Following are examples of features common to all new community projects under active consideration by HUD and some examples of special facilities in a few projects. Because of problems associated with land acquisition by the developers of new communities, only those communities which have been announced by the developer or for which a commitment for a Federal guarantee has been offered by the Secretary, Department of Housing and Urban Development, are included.

1. Features common to all new communities.—

(*a*) Easy pedestrian access to shopping, public service, and recreation areas, with motor and pedestrian traffic separated. Most of the pathways crossing major highways will have grade separations.

(*b*) Pedestrian paths will be through small parks and wooded areas and removed from active play areas.

(*c*) Town, village, and neighborhood centers will offer the physical facilities for learning crafts and skills, forming hobby clubs and continuing education.

(*d*) Low and moderate income housing, much of it with little or no outside upkeep required, will permit the elderly to live close to grandchildren and children in a new community, but not necessarily with the younger family.

(*e*) Internal transportation currently being proposed or explored in most eligible new community developments would provide a means of ready access between neighborhoods, villages, town centers, and residences.

2. Features specific to particular new communities.—(*a*) A typical new community project agreement (that of St. Charles Communities, Md.) contains the following requirements in the development plan.

(1) Each village center will reserve land for medical facilities, including doctors, advisors, out-patient facilities, and group practice facilities. (Village centers are clusters of neighborhoods and are readily accessible by pedestrians living within the neighborhoods. Emphasis will be upon preventive medicine for all residents, including the elderly.)

(2) A hospital and nursing home complex providing outpatient facilities for a housing complex for the elderly is envisioned.

(3) A CATV wide-band telecommunication connection with a major advanced medical institution in the Washington area will be sought to provide diagnostic services for medical facilities within the project.

(4) The developer will encourage other builders within the new community to make application for Federal programs designed to provide housing for the elderly and for low-income families and persons. Rent supplement funds will be sought. At least 10 percent of all rental units will be required to be for persons or families earning less than $5,000 annually many of whom will be the elderly.

(5) On both subsidized and unsubsidized housing, the developer has agreed to use his best efforts to provide housing for people of diverse family size, age and income characteristics within law and moderate income categories.

(*b*) In Park Forest South, Ill., rapid transit connection will make possible low cost, high speed transportation from the new town 30 miles south of Chicago to points throughout the metropolitan area.

(*c*) Both St. Charles Communities, Md., and Jonathan, Minn., are exploring the use of wide-band telecommunications as a part of each home. Such a system might make possible shopping for groceries, clothing, and other household items through a two-way system, television of educational classes, community council meetings, and other activities, as well as billing, recordkeeping and banking facilities, and services into each household.

(*d*) The developers of Jonathan and Ceder Riverside, Minn., both propose the construction of megastructures which will permit the elderly access to shopping areas and town centers through climate-controlled malls and passageways between apartments and commercial areas. Also, "people mover" internal transportation systems are being explored, possibly making use of such devices as moving sidewalks.

Open space and small city parks

The open space program encourages local communities to be aware of the undeveloped needs of any park service area. With grants from this program, various communities have developed specialized parks, for example, tot lots, active recreation areas, and parks for older citizens. Parks developed in areas where senior citizens reside should be developed to meet their needs. A good example of this is the work of the Philadelphia Park Department.

Small towns

The department recognizes the advantages of the "small town way of life" and is continually seeking to improve its services and programs to smaller communities. A basic objective is to preserve and improve both the small and large community—so that citizens will have meaningful opportunities to choose either option. The potential of the small town and new community development

as an alternative to metropolitan congestion and suburban sprawl, and the problem of accommodating a population which will double in the next 50 years is receiving new emphasis and attention.

This effort has significant impact on the population over age 65 since two-thirds of them live in nonmetropolitan areas or small communities outside central cities.

The Office of Small Town Services and Intergovernmental Relations was organized to strengthen relations with State and local governments and provide for improved delivery of programs and services to small towns. A major thrust of this new office is to identify and analyze the housing and community developments needs of small towns and rural areas and recommend appropriate action. This office provides information services and performs general staff and technical assistance and analysis activities. It works with the 10 regional offices and 23 newly established area offices to provide improved program delivery and assist in coordinating Federal, State, local, and private efforts to meet the needs of small towns and the people within them, including the elderly.

To depict how governmental, economic, physical, and social life can be improved through proper use of HUD financial and technical services, a color sound filmstrip called "I Like It Here—Small Town America" has been produced. Also, several specially tailored publications have been prepared to better inform small town officials and residents regarding the full array of housing and community development programs.

1970 HUD awards for design excellence

Housing developments for the elderly have, over the years, won special awards in the biennial HUD design excellence competition. In 1970, an honor award was won by the Wayne, Mich., Housing Commission for its new development for the elderly.

This development is built on three level sites, aggregating 1.65 acres, located in a residential area convenient to a main shopping street. The 10 buildings are made up of 36 identical one-bedroom units, accommodating up to 72 persons. The living units are sited mostly at grade level, though several are a half level above or below grade. Common utility and laundry rooms serve clusters of units; and the apartments are oriented inward to carefully developed courtyards to encourage interaction. Automobile parking is located off the rear alley.

Each living unit has its own balcony or terrace, and walks and landscaping are designed to permit tenant involvement in upkeep. The standard wood construction of the units utilizes stock roof trusses, and the exterior finish is cedar shingles and trim. The jury commended the modest intimate scale achieved in the project. The total development was completed in 1969 at a construction cost of approximately $482,000, including site improvements and equipment.

HEALTH PROGRAMS SERVING THE ELDERLY

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. The maximum mortgage maturity period is 20 years and the current maximum interest rate is 8 percent, effective December 1, 1970, 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. A certificate of need is requested from the appropriate State agency certifying to the need for the nursing home.

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 December 1970 there were 11 FHA-insured nursing home projects which had received Hill-Burton grants. These represent 1,287 beds, $11,612,500 in mortgage amounts and are located in Georgia, Colorado, Arizona, Ohio, Texas, Kentucky, West Virginia, Tennessee, Florida, Massachusttts, and Mis-

souri. In addition to those involving the Hill-Burton program, there are 14 other nonprofit FHA-insured homes. These represent 1,625 beds and $14,864,800 in mortgage amounts.

As of August 31, 1970, the FHA has insured 716 nursing home projects. They contain 70,739 beds and total $529,089,609 in mortgage amounts. Of the 716 nursing homes, 61 are rehabilitation projects. The FHA has received 1,297 applications to contain 126,670 beds and $956,103,042 in mortgage amounts. Of the 1,297 applications received, 100 are rehabilitation projects.

Appendix V contains the highlights of the HUD 1970 Nursing Home Survey covering 493 homes. This report covers information on vacancy, types of accommodations, locations, monthly charges, source of payments and related data. There also is a listing of FHA 232-insured nursing homes with Hill-Burton grants and nonprofit nursing homes with insurance in force.

Intermediate care facilities

Of direct importance to the elderly was the expansion in 1969 of the FHA section 232 nursing home program to include funding for intermediate care facilities. Before this, the major resources of the Department in behalf of the elderly had been for dwellings for the well elderly who are capable of independent living and self-management, and at the other extreme, for nursing homes. A number of older people fall between these poles who cannot live independently and yet do not need skilled nursing home care. Vendor payments under the 1967 Social Security Amendment will make intermediate care facilities usable by recipients of old-age assistance, aid to the blind, and aid to the disabled.

To help finance facilities for this in-between group, section 111 of the 1969 Housing Act authorizes FHA insurance to finance new or rehabilitated intermediate care facilities, or combined nursing homes and intermediate care facilities. These can be financed under the same terms and conditions as provided for a nursing home, and the program is administered by the nursing home branch.

The mortgage is limited to a principal obligation not exceeding $12,500,000 or 90 percent of the estimated value of the property or project including major movable equipment. The Secretary must require certification by the State agency designated by the Public Health Service Act as to the need for such facilities and that there are appropriate standards for their operations.

During 1970, HUD in consultation with the Department of Health, Education, and Welfare completed joint directives relating to the health and medical aspects of intermediate care facilities. Some 24 projects now are in process with seven completed and in operation and six under construction.

Nonprofit hospitals

The 1968 Housing Act authorized FHA to insure mortgage loans on nonprofit hospitals for construction or rehabilitation, including equipment to be used in the operation, under section 242.

The maximum interest rate on these loans is 8 percent, plus one-half of 1 percent mortgage insurance premium and the maximum term is 25 years. The maximum insurable loan is 90 percent of the estimated replacement cost of the building and major equipment, with the limit of $25 million for any one loan. Before insuring any mortgage under section 242, a certification of need must be obtained from the appropriate State agency certifying that there is a need for the hospital.

A memorandum of agreement has been signed between HEW and HUD under which HEW processes hospital facility proposals under the mortgage insurance program, through its regional office, using Hill-Burton procedures and construction and design standards. A Hill-Burton grant may be combined with an FHA-insured loan.

This program became operational in May 1969. As of November 1970, 11 hospital loans had been insured, and firm commitments have been given on 13 additional proposals. A number of additional hospital proposals are being processed by HEW and FHA.

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 conveniently available, particularly to the elderly. In addition, costly hospitalization can be significantly reduced where the group practice is combined with a comprehensive prepayment plan. This 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-replacement cost 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 now 8 percent, plus one-half of 1 percent mortgage insurance premium.

The Office of Economic Opportunity (OEO) can provide equity and operating funds for a group practice facility in conjunction with an FHA-insured mortgage in accordance with an OEO program for health care for low-income people. The group practice program is of particular benefit to senior citizens. Following is a listing of the HUD-insured group practice facilities with OEO involvement.

Insurance in force on OEO assisted facilities

California, 121–51002. San Francisco, Mission Neighborhood Health Center (OEO)	$1,166,900
Missouri, 084–51001. Kansas City, Wayne Minor Neighborhood Health Center (OEO)	1,750,000
Pennsylvania:	
033–51001. Pittsburgh, Homewood-Brushton Neighborhood (OEO) Health Center	1,410,800
034–51001. Philadelphia, West Nicetown-Tioga Family Health Center (OEO)	1,538,800
Tennessee, 086–51001. Nashville, Meharry Neighborhood Health Center (OEO)	1,450,800

HUD HOUSING FOR THE ELDERLY

Demand for housing for the elderly remained high in 1970. The Department of Housing and Urban Development continued to give housing for the elderly close attention through a variety of financial tools using both public and private sponsors.

Housing units specifically designed for the elderly approved or committed for mortgage insurance or annual contributions in public housing during the first 8 months of calendar year 1970 showed an increase in excess of 15,000 units over the same months of 1969. The comparison by major programs for this period follows:

PROGRAMS APPROVED OR COMMITTED (FIRST 8 MONTHS BOTH CALENDAR YEARS)

	1970	1969
Low-rent public housing	33,481	23,666
202 direct loan program	398	3,032
FHA 236 insurance program (interest subsidy)	7,739	0
FHA 231 program	88	0

The cumulative number of approved units from program inception through August 31, 1970:

Low-rent public housing	282,757
202 direct loan program	45,106
FHA 236 program	9,883
FHA 231 and 207 programs	43,657
(1) Mortgages insured and commitments outstanding	-------

The funding of privately sponsored specially designed housing for the elderly in 1970 exceeded any previous year. This in part was influenced by increasing interest of sponsors in helping to meet this very special housing need as well as a major change in method of financing. The section 202 direct loan elderly housing program was replaced by the section 236 mortgage insurance interest subsidy plan of financing. As a result, section 236 funding was provided for a section 202 unfunded backlog of applications involving over 18,000 units estimated to cost over $284.6 million.

With the phasing out of the section 202 elderly housing loan program, housing for the elderly became a part of the total housing need to be met by various programs of HUD rather than identified as a special housing market. This change in method of financing of private housing also brought other significant changes as:

Competitive bidding abandoned in favor of negotiated bids with cost certification.

Sponsorship broadened to include both profit and nonprofit sponsors.

Occupancy of projects designed for the elderly open to nonelderly at discretion of owner.

Projects could be occupied by persons exceeding income limits provided they paid 25 percent of their income for rent (not to exceed market rent) rather than specific income groups only.

Also of great significance was a complete realinement of the organization and functions of the Department of Housing and Urban Development to accelerate housing production and more effectively bring its programs and services to the public. Basically it involves decentralizing approval authorities and funding of all housing programs to the 76 HUD area and FHA insuring offices. Although most of the physical moves are now complete, the training and procedural backup is still in process.

An important aspect of the realinement of the organization and functions was the complete separation of the housing production and the housing management responsibilities. The Assistant Secretary for Housing Production and Mortgage Credit-FHA Commissioner has full responsibility for the development and funding of all housing programs. The Assistant Secretary for Renewal and Housing Management has full responsibility for all completed housing including loan and mortgage payments and administration of foreclosed projects and properties.

Although the clear identity of housing for the elderly as a special program is being phased out, special attention by the Department to this type of housing continues. HUD's elderly housing specialists continue to be an available resource for guidance and assistance to HUD staff and to sponsoring groups interested in housing for the elderly. This staff will develop and/or evaluate policies and guides to help adapt HUD programs to the housing and service needs of the elderly.

One of the roles of the elderly housing specialist will be to meet with groups to facilitate the use of the programs of the Department to meet the varied needs of the older population. The elderly housing specialist will also act as a special consultant to sponsors in troubleshooting and resolving problems which inhibit the effectiveness of HUD programs in serving the elderly.

Since the overwhelming majority of the elderly in HUD programs have low incomes, the HUD assistance programs are the most active in meeting the needs of the elderly.

The low-rent public housing program. This is by far the largest of the assistance programs. Recent changes permit—

The construction of housing specifically designed for elderly couples and single persons.

The leasing of privately owned housing for low-rent purposes.

The acquisition, with or without rehabilitation, of existing privately owned housing for low-rent use.

A simplified procedure for developing new housing, known as Turnkey, under which a local public housing authority may invite a private contractor to build, and sell to the authority, without detailed supervision of design or construction by the authority. Similar Turnkey arrangements are being tried in other areas such as project management to utilize the experience and resources of private enterprise.

Various arrangements under which tenants in public housing projects may become owners of the dwellings they occupy initially as tenants.

Subsidized private housing programs

The housing subsidy programs under private auspices provided in the last decade started with a program for the elderly in 1959 (sec. 202) and a program for moderate income families in 1961 (sec. 221(d)(3) "Below Market Interest Rate"). The section 202 program was financed with direct Federal loans at 3 percent interest for a term of 50 years. The (d)(3) BMIR program was financed with 40-year, 3-percent, below-market-interest-rate mortgages, which were purchased by the Federal National Mortgage Association. Income limits were established for admission to the housing provided under both programs. The subsidy under each program was provided in the form of the lower rents made possible by the low-interest-rate loans. In each case the cost of the capital financing was a direct charge against the Federal budget. Both of these programs are being phased out.

The rent supplement program for low-income families, enacted in 1965, paved the way for the use of direct Federal subsidies to provide housing for low-income families by reducing rentals and ownership costs to tenant or home purchasers. Under this program, the subsidy is in the form of rent-reduction payments. Income limits for eligibility are set generally at the same level as for public housing.

To date, rent supplement reservations have been approved under sections 202 and 231 for over 4,200 elderly persons or families in 162 projects and are receiving rent supplement payments totaling $3.7 million per year. Units occupied by elderly households in projects under other programs are not identifiable.

The section 235 subsidized homeownership and section 236 subsidized rental and cooperative housing programs were introduced in 1968 with a different form of subsidy. Under these programs, monthly mortgage payments and rental charges are reduced through interest-reduction payments which may bring the effective interest rate down to as low as 1 percent. Income limits for these two programs generally are set 35 percent above the public housing limits, with the exception that 20 percent of the families may have somewhat higher income. Under these programs, the capital cost of the housing is financed by insured mortgages, which are privately held.

The financing of the capital cost of the housing is outside the Federal budget. These programs also provided greater flexibility in serving families in varying income. For these reasons, the section 236 program is replacing both the section 221(d)(3) BMIR program, and the section 202 program for the elderly.

In considering the change in method of financing from a direct loan to an insured loan with interest subsidy, it should be noted that the section 202 elderly housing loan program did not receive adequate funding (about $85 million per year) and an enormous backlog of proposals developed. The Department, after careful study, concluded that the financing needs for housing for lower income elderly could best be met under the section 236 interest subsidy mortgage insurance program. HUD proceeded on this basis and, prior to June 30, 1970, allocated approximately $17 million section 236 interest subsidy contract authority to permit processing and approval of approximately $284 million. This funded practically the entire backlog of applications in process.

In addition, proposals totaling approximately $330 million had been worked on extensively by sponsors and submitted to the Department where they were held without action pending future funding. It is planned to fund these also under section 236. This will require approximately $17 million of the section 236 funds in the 1971 appropriations act. These projects are now being funded.

Because of the significant proportion of the total section 236 contract authority being allocated to housing for the elderly and the very heavy demand to fund other areas of need, funding of new housing for elderly proposals has been restricted until fiscal year 1972. New proposals for housing for the elderly will be accepted subject to future funding but cannot be processed until funding can be assured.

Many variations in type of housing and sponsorship are authorized within the housing programs. Existing housing, with or without rehabilitation, is eligible for mortgage insurance under the FHA homeownership programs. Under some of the rental programs, cooperative or condominium variants are available. Different subsidy programs may be combined to produce larger subsidies and an economic mix. For example, rent supplements can be provided for some tenants in a 221(d)(3), 202, or 236 project; and all or part of the units in a privately owned 221(d)(4) project or a 221(d)(3) market rate project may be leased by a local public housing authority.

The forms of sponsorship permitted vary among the programs, with the subsidized, insured mortgage programs largely limited to nonprofit, limited distribution or cooperative sponsorship. Subsidized housing under the mortgage insurance programs is privately owned and managed, with few exceptions; low-rent public housing is owned and managed by local public housing authorities.

The limited subsidy programs largely serve young families, with an average age of about 30 years, and very few elderly. The homeowner families are larger, averaging four persons as compared with two and one-half for the renter families. Under both of these programs about one-fourth of the families have female heads. Families have incomes averaging between $5,500 and $6,000 under both programs. Under the rental program about 43 percent of the dwellings are occupied by minority families.

The deeper subsidy programs serve two distinct age groups, between 35 and 40 percent are elderly and about one-third are under 30. A high proportion—over 50 percent—are either broken families or families with a female head. Family size varies substantially, of course, between the elderly and nonelderly households. About 60 percent of the elderly households consist of single persons and most of the remainder, two persons. In low-rent public housing projects, the nonelderly households average nearly four and one-half persons, with about 30 percent having six or more members. In the rent supplement projects, there are somewhat fewer large households. Average annual income is less than $2,000 for elderly families and from $3,500 to $4,000 for nonelderly families. Under the low-rent public housing program, over half of the dwellings are occupied by minority families. While similar data are not available for the rent supplement program, the proportion of minority occupancy is probably high also.

Under the section 202 limited subsidy program for the elderly, about 80 percent of the dwellings are occupied by single individuals, most of whom are women. The average age is between 70 and 75 years. Incomes average under $3,000.

RENEWAL AND HOUSING MANAGEMENT

Urban renewal 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. Legislation was enacted in 1965 to permit HUD to make direct Federal grants under 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 Office of Renewal Assistance.

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. Under 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 individual or family owning and occupying the 1-to-4 dwelling property in federally aided urban renewal or concentrated code enforcement areas whose incomes are $3,000 or less are eligible for a grant of $3,500 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 individuals and families also are eligible for the direct 3 percent 20-year loans. These loans, not to exceed $12,000 per dwelling unit (or up to $17,400 in high-cost areas), are

available primarily 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 income, the rehabilitation loan also could be used to refinance existing debt on the property. This combination often serves not only to make the rehabilitation possible, but at the same time to reduce substantially 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.

During the period January 1 through September 30, 1970, nearly 4,900 direct loans, covering 7,600 dwelling units for about $33 million were approved. Over 11,000 loans covering 18,700 dwelling units for over $67 million had previously been made since the inception of the program through December 31, 1969. With regard to the grant program, approximately 7,600 grants were approved for about $23 million during the first 9 months of calendar 1970, as compared with cumulative approvals through December 31, 1969, of about 14,700 cases for over $30 million. About 60 percent of the approved grants and 20 percent of the approved loans have been in cases where the head of household was age 62 or over.

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 inception, 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.

Public housing for the elderly

The low-rent public housing program continues to make the greatest contribution of all HUD programs to the provision of standard housing for the elderly population with limited income. Preliminary figures at December 31, 1969, indicate that the total occupied public housing units number 786,264. Some 303,615 were occupied by elderly families or individuals. The median gross rent was $40 per month, including utilities.

Characteristics of the elderly occupants revealed in a year study covering October 1968 to September 30, 1969, give further evidence of need and program responsiveness to it. Elderly occupants increased from 32 to 34 percent of total admissions from 1968 to 1969, with 55,822 taking occupancy during the study period. (In 1959, only 12 percent of all admissions were elderly.) Ten percent of these new elderly public housing residents had incomes under $1,000 per year and 51 percent had incomes under $2,000. Among those single elderly persons admitted, predominantly women, numbered 36,258 with an average income of $1,455. The two-person elderly families number 13,081 and had incomes of $2,316. With respect to source of income, only 3,229 of the total elderly moving in (55,822) received no benefits or assistance. It also is interesting to note that 23 percent of the heads of all families admitted to public housing during the study period were under age 25, and 24 percent were 65 years of age or over.

For the study year, the median gross rent for elderly families admitted was $41, with a median of $45 in the North, $32 in the South, $16 in Puerto Rico, and $51 in the West. It is interesting also that of those elderly moving into public housing, 22,451 moved from physically substandard housing.

Tables extracted from the study appear in appendix VI.

Type of housing varies from community to community, high-rise apartment buildings predominating in large metropolitan areas and low-rise units in the smaller towns and cities. There also is a trend to high-rise apartments for the elderly in smaller cities in order to acquire sites close to main street and make it easy and convenient for the older person to relate to the general community and to have easy access to services and facilities.

Rents.—Section 213 of the Housing and Urban Development Act of 1969 provides that the rent of a public housing tenant may not exceed 25 percent of his income as defined by the Secretary. This limitation became effective by March 24, 1970. The act also provided authority for additional annual contribution payments by HUD which may be used to make up the difference between housing authority expenses and the new 25 percent maximum rent. Since prior to implementation of this legislation the elderly often paid more than 25 percent of their incomes for rent, these provisions will be of great assistance to them.

Modernization.—The criteria for allocating modernization funds have emphasized project age and physical disrepair. While these criteria do not favor projects specially designed for the elderly, they have permitted considerable modernization of elderly public housing projects.

HUD has become increasingly aware of the urgent need for a national program to train housing management personnel. Such a program is now being developed with considerable emphasis on training for management of housing for elderly persons.

SECTION 231—HOUSING FOR THE ELDERLY

During 1970, the Loan and Contract Servicing Division serviced 177 mortgages insured under section 231 of the National Housing Act. The outstanding principal balances of these mortgages total over $292 million and the projects contain over 24,000 units. As of November 30, 1970, seven of the 177 insured mortgages with 888 units and a mortgage amount of $9,932,842 were in default.

During the life of the section 231 program, 49 mortgages have been assigned to the Secretary. Of these 49 mortgages, 29 were foreclosed, one paid in full and 19 are being held by the Secretary. Unfortunately, the history of this program has not been good insofar as the default termination record is concerned.

HUD has discontinued allowing the use of "founders fees" or "life-care fees" in connection with the insurance of new section 231 projects. It is also being stressed that no transfer of physical assets will be approved if the new purchaser intends to use the "founders fees" concept.

SECTION 202—SENIOR CITIZEN HOUSING LOAN PROGRAM

As of October 1970, the Loan and Contract Servicing Division was servicing 248 completed projects. Accountability for all but 34 of these projects had been transferred to Washington. An additional 57 projects were under construction. As required, we have advised and provided guidance to area and regional personnel on problem cases and matters requiring interpretation or clarification.

Of the 214 cases currently assigned to central office accountability, 10 were delinquent in payments as of October 31, 1970. Of these, two were under "workout agreements." A third project was refinanced and the borrower corporation reorganized, but it continues to be a serious problem case. Active endeavors are under way to cure the remaining delinquencies. During 1970, an additional 10–12 cases of delinquency surfaced and were subsequently cured.

Since reorganization, HUD has been emphasizing the necessity of new area and new regional offices to familiarize themselves with projects in their jurisdictions and establish accurate communication of the Office of Loan and Contract Servicing Division of project status by means of the quarterly loan management report, which is entirely new to many of the 27 reporting offices. HUD handbook RHM 7745.1 supplement 1, was prepared and issued to the field.

Examples of inter-agency coordination in housing

Successful housing for the elderly is not shelter alone. Such housing should also provide a range of services and opportunities for a lively and interesting social environment. To achieve this, a variety of organizations and agencies are involved in housing-centered activities. The following few of many examples in 1970 demonstrate the effectiveness of interagency coordination in behalf of a more happy and healthy older population.

Ohio Golden Age villages.—The Ohio Golden Age villages in Columbus and Toledo were undertaken as a public housing experiment to house discharged elderly mental hospital patients along with other elderly people having limited income and assets. In 1970 the concept was incorporated in Ohio's innovative massive mental health program. The State now will move 3,000 elderly people from existing mental hospitals to State-funded geriatric centers providing three types of services: Independent living with minimal dependency care, nursing care for those requiring intermediate care, and extended care. The centers, to cost a total of $31 million, are under development in Toledo, Massillon, Columbus, Dayton, Cincinnati, Northfield and Athens.

St. Louis—community involvement in a senior center.—In St. Louis, community involvement in a senior center, partially funded by a title III grant under the Older Americans Act, is considered assurance of the center's success in continuing after the contract ends. At the invitation of the housing authority, the Cardinal Ritter Institute has operated the senior center since 1968. The center occupies 26,000 square feet on the ground floors of two 16-story high-rises containing 588 dwelling units specially constructed for the elderly. Another 110-unit high-rise is adjacent. Serving the neighborhood and the community, classes are scheduled in arts and crafts, sewing, interior decorating, and millinery. Activities include cards, bingo, tour outings, etc. Instructors are from the board

of education and the city division of parks, recreation and forestry. The public library operates a branch on site. The program director uses the services of a graduate student from St. Louis University's School of Social Service for counseling, information, and referral. When members with health problems visit the health unit, the nurse refers them to the institute's home care program when necessary. Lonely or ill tenants are referred to the friendly visit program. Neighborhood groups encourage elderly persons to become involved in planning for the Yeatman Neighborhood Service projects, and the American Red Cross offers tenants and community residents other opportunities for volunteer work.

Burwell, Nebr. congregate housing.—Meals and homemaker services make the difference between supportive independent living or nursing home care in a congregate housing facility for the elderly operated since July 1967, by the Burwell (Nebr.) Housing Authority. While not the first to include a common dining room in a public housing project, it is unique in developing a network of services by local agencies and organizations. Meals are prepared at nearby Community Memorial Hospital and delivered by van in an electric serving cart to the project's dining room. All dining room furniture and fixtures are owned by the hospital, which also provides outpatient clinic services a half day each week. Homemaker assistance is available for a small fee to residents unable to perform chores for themselves. Homemakers are recruited from elderly residents of the other 20 housekeeping units the authority also operates; they are glad to receive the extra income they earn this way. Three of the 21 tenants in the congregate program use walkers, two are in wheelchairs, and one is blind and deaf; yet, the supportive services make it possible for them to live very much as they would in their own homes. Apartments are either two or three rooms but have no cooking facilities; tenants are expected to do an adequate job of housekeeping. Mrs. Dorothy Van Diest, executive director, needing larger space than the community room provided, secured support from a local private foundation, the Malmsted Charitable Fund, to construct a separate building on site, which is now a communitywide senior center. It was equipped with title III AOA funds, which also staffed a program coordinator. The local council of churches provides transportation assistance and other volunteer services, and worship services are conducted on a rotating basis. The center is continuously active, and is often the scene of special community events such as hobby shows and open house.

University of Georgia training institute.—Short-term training institutes for managers of housing projects, and training of managers of retirement housing—both of special concern to HUD—were projects receiving continued AOA funding in 1970, under title V. The University of Georgia, Athens, was awarded $10,702 for 105 students in a fourth-year grant in the project management; and the University of Arizona, Tucson, received $118,657 in a second-year program for retirement housing managers.

New York City service program.—The New York City Housing Authority took over a 2-year demonstration program serving nearly 1,000 aging residents of four housing projects in South Bronx. Funded principally by the National Institute of Mental Health, the program was continued on a modified basis, first by the Community Service Society of New York, then by the Housing Authority. A team of one supervisor and five service workers made home visits to elderly residents, following through with phone calls and home or office visits. Team members gave advice on social or medical care sources, helped fill out forms, provided cars and shopping help, and did friendly visiting. A project objective was to determine if older nonprofessional persons, 48 to 60, could become effective, given in-service training, on-the-job supervision, and professional back-up. A comprehensive summary and report made this findings: "The results supported the premise that mature workers, carefully screened and employed after review of their background and personal qualities, can discharge circumscribed responsibilities with competence and relative independence. They functioned well as reaching-out agents, expediters, advocates, and friendly supporters. They extended themselves on the job and displayed a genuine sense of commitment."

Chicago housing authority and concerned shoppers.—Consumer education was the subject of a 9-week shopping information seminar promulgated by the Chicago Housing Authority in Cabrini-Green. Widely attended by tenants in the onsite Home Arts Center, it was cosponsored by concerned shoppers among the tenants, and the A. & P. Tea Co. CHA provides community space and tenant and community target populations to secure a wide range of community services and programs in its home arts centers in project developments. Homemaking and health services are provided and taught by community agencies; model apartments have

been set up by residents in several centers to demonstrate comfortable, attractive settings possible on small budgets. The University of Illinois Cooperative Extension Service operates a special program to teach housewives and the elderly economical shopping and nutritious cooking. Cooking classes are popular with teenage girls, as well as with residents of Armour Square Senior Center, from whose ranks the instructors are drawn. On-site facilities, supervised by the Board of Health, are equipped to meet the health needs of the elderly; the Chicago Hearing Society and the American Red Cross sponsor numerous programs. CHA's first medical clinic in a senior citizens' project is located in Flannery Apartments, where free medical services are provided daily, with emergency care always available, by Northwestern University's Medical School.

Services in Minneapolis.—The Hennepin County (Minn.) Welfare Board has set up a special services to the elderly unit of case workers and aides to serve the elderly on the Northside, including many low-rent housing residents of the Minneapolis Housing and Redevelopment Authority. Direct services are supplied, including housekeeping, transportation, friendly visiting, and intensive casework.

Atlanta model cities effort.—In Atlanta, HUD regional, area, and Housing Authority personnel participated in a model cities workshop designed to coordinate HUD–HEW programs and services to the elderly in an $118,000 demonstration grant. The project designed to serve 1,000 elderly clients, is working initially with 120 persons.

Some 80 to 85 percent of them, although living in substandard units in an urban renewal area, are opposed to being moved from their neighborhoods. Leased housing units are being sought for relocation in the area.

Seattle and Tacoma, Wash. services.—The Seattle Housing Authority has invited the University of Washington's Social Work Department to operate on a case work basis on the problem of withdrawal by a number of elderly tenants.

The Tacoma (Washington) Housing Authority has entered into a contract with the sponsor of a 202 elderly congregate housing project to provide dining room service for leased housing elderly tenants in the area. The contract provides for one meal a day, dinner or supper time optional, for $37.50 a month. The housing authority also has an OEO contract which provides recreational programs for the elderly.

Oregon programs.—In Oregon, elderly housing projects in Pope and King Counties cater to the gardening enthusiasms of elderly tenants by supplying gardening plots for flowers and vegetables; rose gardens regularly take prizes. In Portland, a loaves and fishes project sponsored by the community action agency and the council of churches regularly brings food in and prepares meals for the elderly on-site in community rooms.

Disposition of secretary-acquired housing for the elderly

Under the provisions of the National Housing Act, the Secretary has the authority to manage, operate, and dispose of all projects acquired in settlement of claims under any of the various insurance programs. In performing such functions, the Secretary, under subsection 207(1) of the act, is charged with the responsibility of protecting the interest of the general insurance fund. This and other provisions are applicable to section 231 mortgages, incorporated by reference under the provisions of section 231(e) of the act.

The above provision imposes a duty to establish rents at a level which are reasonably competitive in the market, and which will produce a yield sufficient to attract prospective purchasers who may bid for the purchase of the property. This normally requires, prior to a sales offering, obtaining a high stabilized occupancy by renting the dwelling units to all qualified tenants without restriction as to age. If HUD were required to continue such projects as housing for the elderly, this could hinder the disposition program, delay returning the property to private ownership, and reduce the possible dollar recovery to the Secretary.

The regulatory agreement for multifamily housing projects provides occupancy restrictions for mortgages insured under section 231. Paragraph 5 thereof reads as follows:

> (*a*) If the mortgage is originally a Secretary-held purchase money mortgage, or is originally endorsed for insurance under any section other than section 231 or 232, owners shall not in selecting tenants discriminate against any person or persons by reason of the fact that there are children in the family.

(*b*) If the mortgage is originally endorsed for instance under section 221 or 231, owners shall in selecting tenants give to persons or families designated in the National Housing Act an absolute preference or priority of occupancy which shall be accomplished as follows:

(1) For a period of 60 days from the date of original offering, unless a shorter period of time is approved in writing by the Secretary, all units shall be held for such preferred applicants, after which time any remaining unrented units may be rented to nonpreferred applicants;

(2) Thereafter, and on a continuing basis, such preferred applicants shall be given preference over nonpreferred applicants in their placement on a waiting list to be maintained by the owners; and

(3) Through such further provisions agreed to in writing by the parties.

(*c*) Without the prior written approval of the Secretary not more than 25 percent of the number of units in a project insured under section 231 shall be occupied by persons other than elderly persons as defined by the National Housing Act.

(*d*) All advertising or efforts to rent a project insured under section 231 shall reflect a bona fide effort of the owners to obtain occupancy by elderly persons as defined by the National Housing Act.

These requirements, under certain circumstances, would permit a mortgagor to partially or even completely convert the operation of the project from elderly to straight rental housing.

When a project is acquired by the Secretary, irrespective of the section under which the mortgage was originally insured, the local area or insuring office makes a study to determine the current highest and best use of the property. This study takes into consideration the design, utility, and facilities of the project. The location and accessibility of transportation, schools, shopping, churches, medical facilities, and so forth, are all evaluated. The local rental market is surveyed to determine the demand and need for the particular type of housing which may be required, including housing for the elderly.

When a section 231 project is acquired and it is evident that the highest and best use of the project is for occupancy by the elderly the program for the occupancy of the project is established with this objective in view. During the Secretary's operation of a property, the project manager must be obtained through bidding procedures as provided by the Federal procument regulations. To assure to the fullest extent possible that the low bidder for operation of the project is qualified, special requirements are written into the invitation to bid. Thus the program for the property and the award of the contract for the operation of the project sets as its goal the use of the project as originally programed.

If the local office review discloses that the projected original demand for elderly housing no longer exists in the local market, the project is made available to the general rental market, since the Secretary, under his responsibility to protect the general insurance fund, must seek the highest and best use of the property which will return the greatest possible dollar recovery in the disposition of the project. In this respect, it should be noted that this does not preclude occupancy of such projects by elderly persons if they so desire. As a matter of fact, of the projects presently in inventory, eight are directed toward occupancy principally by the elderly and the remainder are occupied by the combination of elderly and the general renting public.

As previously indicated, it is the objective with respect to an acquired multifamily housing project to utilize it for its highest and best use. If in the opinion of the local office the project is located in a climatical area which lends itself to attracting retirees to live there, advertising the availability of rentals is not restricted to the local market. The success of this policy is evidenced by the accomplishments of the Tampa office several years ago.

That office had acquired eight projects located between Clearwater and St. Petersburg in the vicinity of the gulf beaches. Acquisition of these projects was occasioned by the oversupply of apartment accommodations where the mortgages were originally insured under sections 207 and 231. Through extensive advertising in newspapers in the northern, eastern, and central sections of the country, a considerable number of units were occupied by retirees, which occupancy also attracted elderly and retirees in the local market. Thus, these projects were substantially occupied from the elderly segment. Through the efforts of the local office, projects not originally intended for the elderly have been made available to them.

By the reason of a cutback in the space program in the Cape Kennedy area of Florida, it is anticipated that the Secretary will acquire several multifamily projects in addition to the two that were acquired several years ago. The Tampa office has recommended an extensive advertising campaign to attract the elderly into this section of Florida and it is the expectation that the efforts with respect to these projects will be as successful as it was on the west coast of Florida.

There are three projects presently owned by the Secretary that, by reason of their location, lend themselves almost exclusively to occupancy by the elderly. At the present time, these projects are not ready for sale, however, it is felt that when they are offered for sale, they will be advertised with it being specifically stated in the prospectus and invitation to bid that the further operation of the project will be governed by those provisions of the regulatory agreement relating to section 231 operations.

Section 231 of the National Housing Act is not a subsidized program. The requirements for mortgage insurance under section 231 provide that net income must always be sufficient to carry the full debt service.

This requirement for economic soundness does not restrict nonprofit groups from sponsoring elderly housing and the same requirements in Secretary-owned projects would not put them at a disadvantage in bidding for such a project offered for sale.

The following tables show the acquired—sold and use of section 231 projects for the elderly.

HOUSING FOR THE ELDERLY—SEC. 231 PROJECTS

Calendar year	Acquired		Sold	
	Number of projects	Number of units	Number of projects	Number of units
1963	1	183		
1964	5	1,157		
1965	7	1,270	2	283
1966	6	1,470	3	543
1967	13	3,270	3	764
1968	7	1,070	7	1,403
1969			6	1,106
1970	4	768	8	1,385
Total	43	9,188	29	5,484

The following is a breakdown of the purpose for which the above 29 properties were sold:

Elderly housing	6
Rental housing	20
Public housing	1
Student housing	1
School and rental housing	1
Total	29

HOUSING FOR THE ELDERLY—SEC. 231 PROJECTS

[Presently there are 14 sec. 231 projects totaling 3,704 units in our acquired-property inventory]

Year acquired	Number of projects	Number of units
1964	2	393
1965	1	128
1966	1	124
1967	3	1,760
1968	3	531
1970	4	768
Total	14	3,704

Present uses of these on-hand projects are as follows:

Elderly	8
Elderly rental housing	4
Vacant	2
Total	14

NOTE.—Those projects indicated for elderly use are not restricted to such but are principally occupied by elderly persons.

1970 HOUSING LEGISLATION

IMPLICATIONS FOR THE ELDERLY

1970 Uniform Relocation Act

With the vast increase in public programs in densely populated urban areas, the dislocation from homes and businesses has caused the affected citizens, including the elderly, to bear the burden of meeting these public needs. To alleviate this situation, the Uniform Relocation Assistance and Real Property Acquisition Act of 1970 was signed by the President on January 2, 1971. This act responds to the fact that relocation is a serious and growing problem in the United States and that the pace of displacement will accelerate in the years immediately ahead. The committee report states that it "recognizes that advisory assistance is of special importance in the relocation process especially for the poor, nonwhite, the elderly, and people engaged in small business."

Several features of this act may well benefit the older population who must leave their homes and seek new housing arrangements. Fixed payment limitations for moving expenses have been increased for individuals and families from $200 to $500. Additional relocation payments to rent housing or make a down payment have been increased from $1,000 to a maximum of $4,000 based on an assistance period extended from 2 to 4 years; replacement housing payments will not cover any kind of housing (formerly only single or two-family dwellings) and the amount is increased from $5,000 up to a maximum of $15,000. This may include giving up owner-occupied housing, financial assistance will be available to cover the differential in the aggregate interest and other debt service.

Since many elderly owner occupants find difficulty in finding replacement housing they can afford, this liberalization of funds for defraying at least the financial difficulty is significant. In addition, a relocation advisory service is established to minimize hardships in adjusting to relocation. This service can be valuable to the elderly, particularly to the lone woman not experienced in real estate transactions or in finding housing resources.

1970 Housing Act

The Housing Act of 1970, signed by the President on December 31, 1970, fills the gap in housing programs for the elderly by recognizing the needs of the frail but not ill older persons. Rental congregate housing with both public and private sponsors is expressly endorsed. Such housing should alleviate the necessity for premature residence in medically oriented institutions.

The Secretary is authorized to insure mortgages covering rent supplements and section 236 rental assistance projects designed to be occupied by displaced, elderly or handicapped persons. Those projects may contain community kitchens, common dining areas, and other shared facilities. Up to 10 percent of section 236 interest reduction payments and 10 percent of the contracts to make rent supplement payments may be made with respect to such congregate facilities.

Congregate public housing also is included. In the provision of housing predominantly for displaced, elderly, or handicapped families, the Secretary of HUD is directed to encourage public housing agencies to develop such housing wherever practicable, for use in whole or in part as congregate housing. Congregate housing is defined to mean projects with central dining facilities where some or all of the units do not have kitchen facilities. Expenditures incurred in connection with the operation of a centralized facility (except food and service costs) shall be treated as administrative costs of the project. Again, up to 10 percent of the newly authorized annual contribution contract authority can be set aside for this congregate program for the low-income elderly, displaced, or handicapped persons.

Through these enactments we will be in a better position in the years ahead to provide residential facilities and services needed by millions of older people caught between inability to live independently but not needing the costly and

socially less desirable medical facility. It is foreseen that residents of such congregate facilities will be as self-sustaining as their capacity will permit, will have "their own front door key" and services, such as nutrition programs, will be developed to sustain an independent environment as long as health permits. It also may mean, as the program is developed, that many older people in nursing homes may now be accommodated in congregate housing projects.

The act also makes clear that tenants may serve on boards of local housing authorities. This reinforces the President's expressed desire to involve older people in the planning and operation of programs established in their behalf. For the private nonprofit sponsor of housing (a group active in the field of housing for the elderly), the act requires that a Special Assistant to the Secretary of HUD be designated to provide an information and advice service to nonprofit sponsors to assure their continued involvement in the provision of nonprofit housing for all age groups. The Secretary also is authorized to make grants for training in housing management training and for research and information programs related to housing management. This may portend employment opportunities for some active older residents of low- and moderate-income housing.

FHA insuring authority on home improvements, mobile home loans, and group medical facilities, programs of interest to the older population, was extended to October 1, 1972. When a mobile home is composed of two or more modules, the insurable loan is increased from $10,000 to $15,000 and the term is increased to 15 years. Public housing authorization, which includes housing for the elderly, was increased by $150 million for the current fiscal year, thus permitting the current backlog of applications to be serviced and moved into construction. In addition, $225 million is authorized for fiscal year 1972.

Another important provision relating to the elderly is found at section 208 of the act. This section amends section 2(1) of the Public Housing Act to provide a statutory definition of income for the purpose of establishing maximum rentals at one-fourth of tenant income. Family income equals the gross income of all household adults less several exclusions and deductions, including an automatic exclusion of 5 percent of the family's gross income which rises to 10 percent in the case of elderly families.

Rent supplement payments, in FHA private units, a large number of which are used by the elderly, are increased by $40 million effective July 1, 1971; the maximum insurable amount on FHA mortgages covering hospitals is doubled to $50 million; authority to enter into contracts to make section 236 interest reduction payments is increased by an additional $55 million. This program, of course, covers housing for lower income families of all ages.

Many other sections of the legislation forecast an improved environment for all age groups including the older population. For instance, the new program to demonstrate ways to revitalize neighborhoods threatened with abandoned buildings will certainly have a happy impact on many elderly poor required to live in such areas due to restricted income. Too often millions of elderly poor must resort to inexpensive old buildings for shelter.

The 1970 act places responsibility on the Federal Government for the development of a national urban growth policy which shall incorporate social, economic, and other appropriate factors. The act speaks also to a variety of new types of assistance for new community developments while requiring that these new communities "make substantial and appropriate provision for housing within the means of persons of low- and moderate-income." Since new towns or villages have particular appeal to many retirees, the emphasis on economically balanced neighborhoods, the detailed planning guides for safety and convenience, for transportation, for community facilities holds out the promise that safe and attractive new environments may be developed for the older population seeking escape from the inner city or seeking an improved environment in new towns-in-town. The provision of services would be facilitated by the joint or common use of funds from different Federal assistance programs for interrelated projects or activities that are being undertaken as part of a new community development program. Some present new towns are beginning to provide facilities and services peculiarly related to the needs of the older resident. We may expect a continuation or expansion of this concept under the new act.

Improvement in rural housing programs are also included in the 1970 Housing Act. Rural housing loans may now be made to lessees as well as to owners of nonfarm leaseholds, loans for improvements to existing farm housing are increased from $1,500 to $2,500 or larger amounts if water supply or plumbing facilities are involved; and the maximum loan allowable for rural rental housing for the elderly is increased from $300,000 to $750,000. Definition of "rural"

also is expanded and may now cover places up to 10,000 population if it is rural in character. These rural housing programs are administered by the Department of Agriculture.

CONCLUSION

National interest in the well-being of the older population continued in 1970, and was reflected by the increase in housing and health programs in HUD.

In 1970 the President called a White House Conference on Aging for 1971, and housing will be one of its major concerns. HUD has provided staff work to the Conference to assist in formulating the environmental and shelter issues. A citizen committee representing all aspects of housing was appointed in 1970. This committee has held several meetings, developed a housing background paper, and set forth the major housing issues facing the Nation and the older population. The HUD representative is Chairman of a Federal agency Secretariat, representing all departments with programs for the elderly.

As further issues are raised in local and State pre-Conference meetings during 1971, these will be collated by the Housing Committee and Secretariat for consideration by the Conference delegates.

The President designated 1970 as the year of preparation for the Conference on Aging; 1971 as the Conference year, and 1972 as a year for action on Conference recommendations.

Thus, the Nation's efforts to bring about economic and social adjustments in the society required by the phenomenon of longevity continue at the highest level of government.

HIGHLIGHTS OF NURSING HOME SURVEY

The Department of Housing and Urban Development's annual nursing home survey was conducted as of January 15, 1970. The response was from 463 nursing homes that had received permits for initial occupancy from the appropriate State agencies. Information on vacancy, types of accommodations, locations, monthly charges, source of payments, and related data were provided.

The nursing homes were located in 46 States and the District of Columbia. They had 45,083 beds and 38,155 patients on the survey date for an average of 97 beds per home. Sixty-eight percent of the homes and 75 percent of the beds were in metropolitan areas. Nursing homes in metropolitan areas reported an average of 108 beds compared to an average of 76 beds in nonmetropolitan areas.

OCCUPANCY-VACANCY CHARACTERISTICS

As of January 15, 1970, the overall vacancy rate was 15.4 percent. Generally, projects that began operation most recently experienced the highest vacancy rates. For projects opening in 1969, the vacancy rate of 39 percent compares with slightly over 13 percent for projects opening in 1968 and less for prior years, except 1965 openings, for which the average was just under 15 percent.

Type of accommodation and location

Nationally, vacancy rates did not differ significantly among accommodations in private, semiprivate and ward rooms. Of the 3,887 beds available in private rooms, 13.9 percent were vacant. The corresponding vacancy rates for the 32,028 beds in semiprivate rooms and the 9,168 beds in wards were 15.7 and 14.7 percent, respectively.

Of the 38,155 patients, approximately 9 percent were accommodated in private rooms, 71 percent in semiprivate rooms, and 20 percent in wards of three or more beds. About 76 percent of the patients were located in homes in metropolitan areas compared with 24 percent in nonmetropolitan places.

Monthly charges and source of payment

At the time of the survey, the median monthly charge per bed for all types of accommodations was $473. Charges were substantially higher in metropolitan areas than in nonmetropolitan places, the medians being $496 and $389, respectively.

The median charges by type of accommodation were $632 for private rooms, $471 for semiprivate rooms, and $436 for ward accommodations.

FHA nursing homes reported that 45 percent of the patients met their monthly expenses with private funds. Twenty percent received assistance under the medicaid program, 19 percent received welfare payments, 14 percent were aided by medicare, and 1 percent received assistance from other sources, such as the Veterans Administration.

Over the last three survey periods, there have been only minor changes in the percentages of patients supported by welfare payments or other sources. In contrast, there has been a substantial shift from dependence on private funds and medicare to the use of medicaid, reflecting the increasing acceptance of the medicaid program by the States.

PERCENTAGE DISTRIBUTION OF PATIENTS BY SOURCE OF PAYMENT

Date of survey	Private funds	Welfare payments	Medicare	Medicaid	Other
Dec. 15, 1967	50.4	19.5	26.8	1.8	1.5
Jan. 15, 1969	45.0	18.7	23.4	11.6	1.3
Jan. 15, 1970	45.3	19.0	14.3	20.4	1.0

The median monthly charge for patients meeting expenses through private funds was $494; for patients receiving welfare payments, the median charge was $348. The highest median monthly payment was made by medicare patients, who paid $595. For medicaid patients, the median monthly charge was $439.

Race of patients

Nonminority white persons constituted 92.7 percent of the patients for whom race was reported; Negroes, 5.2 percent; and Spanish Americans, 1.1 percent. American Indians, Orientals, and others each accounted for less than 0.1 percent.

Percentage changes in basic schedule of charges

Seventy percent of the nursing homes which reported changes in their monthly charges indicated their charges had increased during the preceding year. Three percent had decreased their rates while the remaining 27 percent of the nursing homes had had no change in their basic charges.

Published copies of the 1970 survey of FHA-assisted nursing homes will be available at a later date and will include a more detailed analysis. Fourteen tables, which provide comparative data by regional distribution and when significant by metropolitan and nonmetropolitan location, will accompany the report.

NURSING HOMES WITH HILL-BURTON GRANT

Project No.	Name, city, and State	Beds	Mortgage
Insurance in force:			
061-43020	Happy Haven Nursing Home, Atlanta, Ga	158	$621,000
101-43009	City Park Manor Nursing Home, Denver, Colo	120	873,200
123-43010	Tanner Chapel Manor Nursing Home, Phoenix, Ariz	50	325,000
043-43016	Wesley Glen Nursing Home, Columbus, Ohio	44	540,000
114-43010	Schlesinger's Home, extended care facility, Beaumont, Tex	204	1,611,200
083-43021	Caverna Convalescent Home, Horse Cave, Ky	34	433,000
045-43011	Greenbrier County Nursing Home, Fairlea, W. Va	100	850,000
087-43010	Presbyterian Home of Tennessee, Knoxville, Tenn	200	2,498,000
066-43024	Lutheran Medical Center, Miami, Fla	197	2,137,000
023-43034	Union Mission Nursing Home, Inc., Haverhill, Mass	120	1,160,000
085-43024	Beth Haven Nursing Home, Hannibal, Mo	60	563,600
Total		1,287	11,612,500

NONPROFIT NURSING HOMES

Insurance in force:			
101-43013	Crowley Convalescent Center, Ordway, Colo	50	340,300
071-43026	Deliverance Nursing Home, Chicago, Ill	199	1,349,600
072-43030	La Moine Christian Nursing Home, Roseville, Ill	62	689,100
023-43014	Peoples Church Nursing Home, Worcester, Mass	80	779,500
092-43010	Hendricks Nursing Home, Hendricks, Minn	40	346,600
092-43011	Lutheran Retirement Home, Truman, Minn	63	600,000
084-43011	Montabaur Club, Kansas City, Mo	136	2,413,800
031-43070	Park View House, Wayne, N.J	120	1,512,600
042-43013	Winebrenner Extended Care Facility, Findlay, Ohio	106	1,250,000
126-43018	Colonial Manor, Portland, Oreg	100	547,900
034-43014	Sarah Allen Home, Philadelphia, Pa	199	1,011,000
081-43011	Howard Manor Christian Nursing Home, Memphis, Tenn	50	288,100
075-43032	Downtown Nursing Home, Milwaukee, Wis	260	2,536,300
075-43025	Methodist Manor Health Care Center, West Allis, Wis	160	1,200,000
Total		1,625	14,864,800

APPENDIX VI

TOTAL ANNUAL FAMILY INCOME OF ALL FAMILIES AND OF SENIOR CITIZENS WHO MOVED INTO LOW-RENT HOUSING, BY NUMBER OF PERSONS

[12 months ended Sept. 30, 1969]

Total family income	Number of persons			
	1	2	3 or 4	5 or more
Number moving in:				
All families	38,054	34,657	52,648	38,873
Senior citizens	36,258	13,081	3,968	2,378
Percent—all families	100	100	100	100
Under $1,000	14	4	2	1
$1,000 to $1,499	40	13	7	3
$1,500 to $1,999	23	21	12	6
$2,000 to $2,499	13	18	16	9
$2,500 to $2,999	6	14	15	12
$3,000 to $3,499	2	13	15	16
$3,500 to $3,999	1	9	12	16
$4,000 to $4,999	1	7	13	20
$5,000 to $5,999	(1)	2	6	10
$6,000 and over	(1)	1	3	8
Median income:				
All families	$1,456	$2,346	$2,922	$3,612
Senior citizens	$1,455	$2,316	$2,968	$3,858

[1] Less than 0.5 percent.

Source: Department of Housing and Urban Development, Office of Housing Management Statistics Branch.

ASSISTANCE AND BENEFITS RECEIVED BY SENIOR CITIZENS AND BY FAMILIES[1] WHO MOVED INTO LOW-RENT HOUSING

[12 months ended Sept. 30, 1969]

Assistance and benefits	Total	Families[1]	Senior citizens
Number moving in	164,872	109,050	55,822
Percent	100	100	100
No assistance or benefits	35	50	6
Assistance only	32	41	15
Assistance and OASI	7	2	18
Assistance and benefits other than OASI	1	1	1
Assistance, OASI and other benefits	(2)	(2)	1
OASI only	17	3	46
OASI and other benefits	4	1	11
Other benefits only	3	3	3

[1] Limited to those not qualifying as families of senior citizens.
[2] Less than 0.5 percent.

Source: Department of Housing and Urban Development, Office of Housing Management, statistics branch.

TOTAL ANNUAL FAMILY INCOME OF SENIOR CITIZENS WHO MOVED INTO LOW-RENT HOUSING, BY NUMBER OF ADULTS, BY ASSISTANCE AND BENEFITS AND BY RACE—12 MONTHS ENDED SEPT. 30, 1969

Total family income	Total				1 adult				2 or more adults			
	Total	No benefits or assistance	Assistance with or without benefits	Benefits only	Total	No benefits or assistance	Assistance with or without benefits	Benefits only	Total	No benefits or assistance	Assistance with or without benefits	Benefits only
Number moving in [1]	55,822	3,229	19,209	33,384	39,070	1,500	13,350	24,220	16,752	1,729	5,859	9,164
Percent	100	100	100	100	100	100	100	100	100	100	100	100
Under $1,000	10	4	9	11	13	8	12	14	2	1	2	2
$1,000 to $1,499	29	8	34	29	38	14	45	36	8	2	10	9
$1,500 to $1,999	21	6	23	22	23	11	22	24	18	2	25	16
$2,000 to $2,499	15	8	15	15	13	12	12	13	19	4	21	21
$2,500 to $2,999	9	8	7	11	7	12	4	8	15	5	14	18
$3,000 to $3,499	6	11	4	6	3	15	2	3	12	8	10	14
$3,500 to $3,999	3	10	3	3	1	10	2	1	8	10	7	9
$4,000 to $4,999	3	17	3	2	1	11	1	(2)	9	23	8	7
$5,000 to $5,999	1	11	1	1	(2)	5	(2)	(2)	4	17	2	2
$6,000 and over	1	17	1	(2)	(2)	3	(2)	(2)	4	29	1	1
Median income	$1,753	$3,755	$1,657	$1,734	$1,482	$2,712	$1,429	$1,493	$2,576	$4,804	$2,311	$2,545
White	38,071	1,220	10,370	26,481	27,619	798	7,136	19,685	10,452	422	3,234	6,796
Percent	100	100	100	100	100	100	100	100	100	100	100	100

Under $1,000	10	8	8	11	13	11	11	13	2	3	2	2
$1,000 to $1,499	31	13	35	30	39	18	46	37	9	4	11	8
$1,500 to $1,999	23	9	25	23	24	11	25	25	19	5	27	16
$2,000 to $2,499	16	13	17	16	13	13	14	13	22	13	23	22
$2,500 to $2,999	10	13	6	11	7	14	3	8	17	12	14	19
$3,000 to $3,499	5	16	4	6	3	16	1	3	13	15	10	15
$3,500 to $3,999	3	10	2	3	1	9	(2)	1	8	14	6	9
$4,000 to $4,999	2	11	2	2	(2)	6	(2)	(2)	7	21	5	6
$5,000 to $5,999	(2)	4	(2)	(2)	(2)	2	(2)	(2)	1	8	1	1
$6,000 and over	(2)	3	(2)	(2)	(2)	1	(2)	(2)	1	7	1	1
Median income	$1,709	$2,772	$1,628	$1,719	$1,481	$2,386	$1,420	$1,496	$2,451	$3,483	$2,221	$2,530
Negro and other	17,613	2,001	8,820	6,792	11,352	698	6,202	4,452	6,261	1,303	2,618	2,340
Percent	100	100	100	100	100	100	100	100	100	100	100	100
Under $1,000	10	2	9	12	14	5	12	17	2	1	2	3
$1,000 to $1,499	27	4	33	26	37	10	43	35	8	1	9	10
$1,500 to $1,999	18	4	20	20	20	11	19	22	16	1	22	16
$2,000 to $2,499	13	5	13	15	12	10	11	13	15	2	18	18
$2,500 to $2,999	8	5	8	10	6	9	5	8	12	3	15	14
$3,000 to $3,449	6	8	5	6	4	14	3	3	10	5	9	12
$3,500 to $3,999	5	9	4	4	3	11	3	1	8	8	7	9
$4,000 to $4,999	6	21	5	4	3	16	3	1	13	23	10	10
$5,000 to $5,999	3	16	1	2	1	8	(2)	(2)	7	20	4	4
$6,000 and over	4	25	1	1	1	6	(2)	(2)	10	36	3	4
Median income	$1,871	$4,565	$1,699	$1,799	$1,483	$3,171	$1,441	$1,476	$2,904	$5,282	$2,448	$2,601

[1] Includes families for whom data on race were not available.
[2] Less than .5 percent.

Source: Department of Housing and Urban Development, Office of Housing Management, Statistics Branch.

TOTAL ANNUAL FAMILY INCOME OF ALL FAMILIES AND OF SENIOR CITIZENS WHO MOVED INTO LOW-RENT HOUSING, BY SERVICE STATUS AND BY DISPLACEMENT STATUS, 12 MONTHS ENDED SEPT. 30, 1969

Total family income	All families			Families displaced by public action			Families not displaced by public action		
	Total	Veterans and servicemen	Other	Total	Veterans and servicemen	Other	Total	Veterans and servicemen	Other
Number moving in:									
All families	164,872	28,117	136,755	18,621	2,383	16,238	146,251	25,734	120,517
Senior citizens	55,822	8,166	47,656	5,845	761	5,084	49,977	7,405	42,572
Percent, all families	100	100	100	100	100	100	100	100	100
Under $1,000	5	2	5	5	3	6	5	2	5
$1,000 to $1,499	15	7	16	12	7	13	15	7	17
$1,500 to $1,999	15	13	16	13	13	13	16	13	16
$2,000 to $2,499	14	13	14	12	12	12	14	14	14
$2,500 to $2,999	12	13	12	11	9	11	12	13	12
$3,000 to $3,499	12	12	12	11	10	11	12	13	12
$3,500 to $3,999	10	11	9	10	10	10	9	11	9
$4,000 to $4,999	11	14	10	13	15	12	10	14	9
$5,000 to $5,999	5	8	4	7	11	6	4	8	3
$6,000 and over	3	6	2	6	11	5	3	5	2
Median income:									
All families	$2,548	$3,074	$2,442	$2,835	$3,308	$2,777	$2,514	$3,057	$2,407
Senior citizens	1,753	2,100	1,679	1,819	2,170	1,755	1,746	2,105	1,671

Source: Department of Housing and Urban Development, Office of Housing Management, Statistics Branch.

TOTAL ANNUAL FAMILY INCOME OF SENIOR CITIZENS AND OF FAMILIES [1] WHO MOVED INTO LOW-RENT HOUSING BY CENSUS REGION AND FAMILY COMPOSITION [2]—12 MONTHS ENDED SEPT. 30, 1969

Total family income	Senior citizens				Families [1]
	Total	Single persons	2 or more adults	With minors	
Total number moving in	55,671	36,178	12,437	7,056	108,026
Percent	100	100	100	100	100
Under $1,000	10	14	2	3	2
$1,000 to $1,499	29	40	10	9	7
$1,500 to $1,999	22	24	21	12	12
$2,000 to $2,499	15	13	22	13	14
$2,500 to $2,999	9	6	17	13	13
$3,000 to $3,499	6	2	12	11	15
$3,500 to $3,999	3	1	7	10	13
$4,000 to $4,999	3	(3)	6	14	14
$5,000 to $5,999	1	(3)	2	7	6
$6,000 and over	1	(3)	1	8	4
Median income	$1,737	$1,455	$2,390	$3,002	$3,048
North, number moving in	29,939	20,200	6,279	3,460	3,048
Percent	100	100	100	100	100
Under $1,000	7	10	1	1	1
$1,000 to $1,499	28	40	6	3	5
$1,500 to $1,999	21	25	16	6	9
$2,000 to $2,499	14	12	21	9	12
$2,500 to $2,999	10	7	20	13	12
$3,000 to $3,499	6	3	14	10	12
$3,500 to $3,999	4	1	9	12	12
$4,000 to $4,999	5	1	8	21	19
$5,000 to $5,999	2	(3)	3	11	10
$6,000 and over	3	(3)	3	16	7
Median income	$1,844	$1,496	$2,674	$3,896	$3,427
South, number moving in	19,008	11,282	4,918	2,808	47,235
Percent	100	100	100	100	100
Under $1,000	16	23	4	7	4
$1,000 to $1,499	35	48	17	18	11
$1,500 to $1,999	20	17	28	21	14
$2,000 to $2,499	13	8	24	18	13
$2,500 to $2,999	7	3	13	12	14
$3,000 to $3,499	4	1	8	10	18
$3,500 to $3,999	2	(3)	4	7	14
$4,000 to $4,999	2	(3)	2	5	10
$5,000 to $5,999	(3)		(3)	1	2
$6,000 and over	(3)	(3)	(3)	1	1
Median income	$1,485	$1,243	$2,010	$2,112	$2,773
West, number moving in	6,724	4,696	1,240	788	19,435
Percent	100	100	100	100	100
Under $1,000	4	5	1	1	1
$1,000 to $1,499	17	23	4	3	3
$1,500 to $1,999	28	35	16	8	14
$2,000 to $2,499	24	27	20	14	17
$2,500 to $2,999	10	7	19	15	15
$3,000 to $3,499	7	2	20	17	13
$3,500 to $3,999	4	(3)	12	12	12
$4,000 to $4,999	3	(3)	6	18	15
$5,000 to $5,999	1	(3)	(3)	6	7
$6,000 and over	(3)	(3)	(3)	2	3
Median income	$2,019	$1,824	$2,754	$3,261	$3,037

[1] Limited to those not qualifying as families of senior citizens.
[2] Excludes Alaska, Hawaii, Puerto Rico and the Virgin Islands.
[3] Less than 0.5 percent.

APPENDIX VII (1).—FEDERALLY AIDED PUBLIC HOUSING PROJECTS WITH ALL OR SOME UNITS DESIGNED SPECIFICALLY FOR THE ELDERLY, WITH ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED, CUMULATIVE THROUGH DEC. 31, 1969

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	218,909	1,398	136,089	1,789	82,820
Alabama	3,932	21	1,205	125	2,727
Alaska	25			1	25
Arizona	257		96	6	161
Arkansas	4,217	26	1,570	98	2,647
California	10,104	27	2,345	59	7,759
Colorado	1,121	11	1,003	8	118
Connecticut	4,482	49	4,100	8	382
Delaware	744	2	383	5	361
District of Columbia	2,120	7	1,245	9	875
Florida	6,984	35	4,599	38	2,385
Georgia	4,453	23	1,968	110	2,485
Hawaii	774	4	422	8	352
Idaho	200	4	170	1	30
Illinois	17,427	119	12,911	123	4,516
Indiana	4,046	25	3,630	19	416
Iowa	1,330	18	853	7	477
Kansas	2,652	16	1,280	18	1,372
Kentucky	4,591	23	2,504	93	2,087
Louisiana	3,578	14	832	74	2,746
Maine	1,003	8	873	3	130
Maryland	1,967	9	909	11	1,058
Massachusetts	10,357	79	7,011	25	3,346
Michigan	8,051	70	6,532	34	1,519
Minnesota	12,001	78	9,426	17	2,575
Mississippi	485	2	130	11	355
Missouri	4,058	18	1,561	46	2,497
Montana	106	2	90	2	16
Nebraska	4,614	76	3,643	20	971
Nevada	759	3	475	4	284
New Hampshire	1,788	18	1,325	8	463
New Jersey	14,402	85	12,619	37	1,783
New Mexico	607	4	192	18	415
New York	19,869	54	6,430	112	13,439
North Carolina	3,769	17	2,185	74	1,584
North Dakota	606	12	451	3	155
Ohio	11,788	64	7,271	33	4,517
Oklahoma	3,177	12	1,346	58	1,831
Oregon	2,649	11	871	12	1,778
Pennsylvania	11,969	81	7,726	79	4,243
Puerto Rico	726	4	598	13	128
Rhode Island	4,469	37	4,100	5	369
South Carolina	924	6	577	9	347
South Dakota	282	4	198	12	84
Tennessee	5,507	28	3,325	97	2,182
Texas	7,376	79	5,230	178	2,146
Utah					
Vermont	357	3	292	3	65
Virginia	679	3	308	7	371
Virgin Islands	159	1	85	7	74
Washington	4,966	49	4,116	15	850
West Virginia	1,606	10	1,196	14	410
Wisconsin	4,736	47	3,882	11	854
Wyoming	60			1	60

APPENDIX VII(2)

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED OCT. 1, 1969, THROUGH SEPT. 30, 1970 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Alabama:			
Arab [1]	54	16	$938
Athens [1]	100	25	1,749
Atmore	68	30	1,319
Auburn	125	25	2,120
Bayou La Batre [1]	50	16	852
Bessemer	100	100	1,545
Brilliant	40	14	637
Carbon Hill	40	20	752
Daleville	70	20	1,246
Decatur	201	151	3,478
Detroit	66	14	1,239
Hamilton	70	24	1,061
Jasper	150	100	2,237
Lineville	36	15	705
Northport	150	50	2,504
Talladego	250	100	4,498
Winfield	80	40	1,313
York	64	24	1,149
Total, Alabama	1,714	784	29,342
Arizona:			
Maricopa [1]	200	125	5,096
Tucson	200	50	4,691
Total, Arizona	400	175	9,787
Arkansas:			
Beebe	40	16	663
Crossett	80	30	1,543
Heber	70	20	1,391
Helena	150	20	2,917
Little Rock	251	251	4,447
McCory	36	12	638
Marianna	100	30	1,871
Marmaduke	16	8	310
Melbourne	34	18	573
Morrilton	40	30	618
Newport	120	30	2,027
Parkin	20	10	345
Puxora	34	10	674
Recton	40	20	724
Reson	34	14	567
St. Francis	10	4	195
Total, Arkansas	1,075	523	19,503
California:			
Barstow	54	40	968
Livingston	60	6	1,248
Marin County [1]	50	15	1,883
Merced [1]	200	35	4,579
Monterey [1]	100	100	1,822
Napa [1]	200	50	4,485
Oakland	101	100	4,537
Pasadena [1]	250	60	6,500
Plumas County [1]	120	20	2,574
Riverbank	30	30	504
Sacramento	393	368	7,314
Sacramento [1]	175	70	4,342
San Bernardino [1]	150	40	3,405
San Buenaventura [1]	200	30	5,165
San Francisco	108	108	2,127
San Joaquin [1]	250	46	3,150
San Mateo	20	20	259
San Mateo [1]	100	40	2,267
Santa Cruz County [1]	200	44	4,543
Stanislaus County [1]	150	35	3,453
Tulare County [1]	200	10	4,310
Yolo County [1]	100	40	2,050
Total, California	3,211	1,307	71,885
Colorado:			
Aquilar	18	12	$307
Haxtun	22	18	365
Kersey	20	16	318
Pueblo	200	71	3,675
Total, Colorado	260	117	4,665
Connecticut:			
Ansonia [1]	80	80	1,293
Bristol	120	120	2,403
Greenwich	150	150	3,227
Middletown	129	129	2,644
Milford	43	43	748
New Haven	80	80	1,358
Seymour	80	80	1,395
Stamford	122	122	1,928
Waterbury [1]	80	80	1,882
West Haven	200	200	3,520
Total, Connecticut	1,084	1,084	20,398
Delaware: Dover	50	50	976
Florida:			
Brookville	126	36	2,368
Clearwater [1]	484	134	9,513
Daytona Beach	150	150	2,498
Fort Myers	470	120	8,571
Fort Pierce	119	119	1,749
Hialeah	200	200	3,755
Lake Wales	140	28	2,804
Miami	258	258	4,418
Punta Gorda	104	54	1,759
St. Petersburg	336	336	6,129
Sanford	100	100	1,437
Total, Florida	2,487	1,535	45,001
Georgia:			
Athens	118	118	2,176
Atlanta	704	634	12,821
Augusta	100	100	1,738
Barnesville	72	22	1,294
Camilla	100	18	2,021
Cartersville	80	32	1,407
Claxton	22	22	349
College Park	267	46	5,042
Collins	16	6	300
Cordele	60	60	856
Cornelia	30	4	584
Dallas	46	12	876
Hinesville	48	18	903
Jackson	52	20	969
Macon	200	200	3,218
Marietta	102	102	1,717
Marshallville	32	6	539
Metter	18	18	293
Statham	20	6	393
Talbotton [1]	32	12	570
Tallapoosa	80	26	1,498
Tifton	150	52	2,864
Toccoa	75	45	1,298
Unadilla	25	13	462
Warner Robins	104	104	1,361
West Point	55	15	1,009
Total, Georgia	2,608	1,711	46,558
Hawaii:			
Honolulu	124	124	2,317
Lahaina	42	42	837
Total, Hawaii	166	166	3,154

[1] Leased housing.

APPENDIX VII(2)—Continued

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED OCT. 1, 1969, THROUGH SEPT. 30, 1970 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Idaho:			
Boise	93	93	$1,768
Boise City [1]	250	40	6,269
Pocatello	75	75	1,280
Twin Falls	32	32	417
Total, Idaho	450	240	9,734
Illinois:			
Bloomington	162	162	2,575
Centreville	150	12	2,919
Chester	62	38	1,085
Chicago	220	220	3,450
Chicago [1]	748	250	16,987
Decatur	120	120	1,896
East S. Louis	199	199	3,115
Freeport	120	120	1,860
Hardin	12	12	201
Herrin	63	63	1,025
Hoopeston	63	63	999
Jefferson Co	12	8	202
Johnston	30	22	502
Joliet	150	150	2,237
Jonesboro	36	12	638
Kewanee	81	81	1,243
Marseilles	90	90	1,404
Mendota	60	60	973
Norris City	12	12	184
Park Forest	106	106	1,550
St. Claire County	15	15	259
Skokie	127	127	2,025
Sparta	48	22	833
Staunton	18	10	307
Total, Illinois	2,704	1,974	48,469
Indiana:			
Bloomington [1]	190	190	3,387
East Chicago	209	209	3,520
Evansville	230	230	3,718
Gary [1]	300	80	5,927
Total, Indiana	929	709	16,552
Iowa:			
Essex	16	16	249
Ottumwa	101	101	1,632
Shenandoah	80	80	1,153
Total, Iowa	197	197	3,034
Kansas:			
Agra	14	12	236
Clay Center	100	100	1,720
Fort Scott	200	150	3,525
Gaylord	12	10	214
Great Bend	100	100	1,904
Iola	100	60	1,985
Jetmore	20	10	356
Lyons	76	76	1,356
Marion	28	28	530
Minneapolis	50	30	903
Olathe	66	66	1,184
Paola	60	50	1,136
Phillipsburg	32	32	575
Wamego	32	32	580
Total, Kansas	890	756	16,204
Kentucky:			
Ashland [1]	100	100	1,464
Bardstown	80	20	1,509
Catlettsburg	99	99	1,926
Corbin	65	34	1,267
Franklin	110	40	2,079
Fulton	80	32	1,533
Kentucky—Continued			
Georgetown	84	16	$1,676
Glasgow	90	90	1,541
Henderson	100	100	1,328
Hodgenville	70	16	1,280
Jamestown	34	16	679
Lancaster	30	10	621
Louisville	548	546	11,114
Maysville	100	50	2,082
Murray	50	40	777
Pineville	80	40	1,449
Springfield	50	16	987
Total, Kentucky	1,770	1,265	33,312
Louisiana:			
Alexandria [1]	500	120	8,894
Crowley	140	20	2,503
Delhi [1]	40	10	616
DeQuincy	40	18	663
E. Baton Rouge	100	100	1,602
Ferriday [1]	100	30	1,627
Grambling	18	6	297
Lafourche [1]	100	20	1,802
Leesville	150	50	2,554
Mansfield	150	50	2,463
Oil City	28	8	492
Patterson	76	20	1,480
Rayville	100	24	1,614
St. Martinville	68	48	1,017
Westlake	50	30	844
White Castle	58	16	1,020
Winnsboro	150	50	2,429
Total, Louisiana	1,868	620	31,917
Maine:			
Portland	150	150	2,764
Presque Isle	110	50	2,487
Sanford	140	80	2,988
Total, Maine	400	280	8,239
Maryland:			
Anne Arundel	200	200	3,338
Baltimore	150	150	2,490
College Park	109	109	2,027
Montgomery County	96	54	1,341
Total, Maryland	555	513	9,196
Massachusetts:			
Boston	724	724	15,101
Brockton	840	840	12,561
Dracut	75	50	1,558
Fall River	40	40	712
Fall River [1]	200	150	3,010
Lawrence	202	103	4,288
Lowell	208	208	3,883
New Bedford	797	244	17,598
Quincy	276	276	5,084
Shrewsbury	100	100	1,801
Springfield	32	32	538
Waltham	22	22	354
Total, Massachusetts	3,516	2,789	66,488
Michigan:			
Flint [1]	300	100	5,773
Highland Park [1]	46	23	942
Iron Mountain	42	42	651
Iron River	31	31	498
Kingford	71	41	1,281
Lansing	101	101	1,672
Livonia	83	83	1,292
Paw Paw Village	32	32	515

[1] Leased housing.

APPENDIX VII(2)—Continued

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED OCT. 1, 1969, THROUGH SEPT. 30, 1970 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Michigan—Continued			
St. Clair Shores	120	120	$1,877
Taylor	111	111	1,814
Total, Michigan	937	684	16,315
Minnesota:			
Barnesville	32	32	501
Braham	32	32	492
Cambridge	45	45	697
Carlton	20	20	326
Clarkfield	35	35	543
Cloquet	80	80	1,265
Delano	30	30	476
Duluth	211	211	3,310
Ely	41	20	778
Fairmont	125	125	1,941
Forest Lake	42	42	696
Glenwood	30	30	465
Litchfield	61	61	962
Mankato	141	101	2,419
Marshall	105	105	1,572
Melrose	30	30	480
Montevideo	81	81	1,290
Mound	50	50	809
Mountain Lake	42	42	677
Ortonville	70	50	1,207
Pipestone	102	82	1,617
Princeton	41	41	661
Red Lake Falls	26	26	391
St. Paul	194	194	2,883
Staples	61	61	965
Warren	60	50	968
Warroad	20	20	320
Willmar	127	127	1,983
Windom	61	61	973
Total, Minnesota	1,995	1,884	31,667
Mississippi:			
Bay St. Louis	65	30	1,177
Carthage	46	16	788
Gulfport Area [1]	100	100	1,577
Laurel	174	54	3,050
Lowndes County [1]	100	20	1,883
Lumberton	70	20	1,353
Newton [1]	70	30	1,230
Pass Christian	90	20	1,766
Starkville	114	30	1,970
Vicksburg	150	40	2,864
Waveland	75	15	1,428
West Point	60	18	932
Total, Mississippi	1,114	393	20,018
Missouri:			
Boonville	50	20	1,074
Brookfield	90	60	1,632
Caruthersville [1]	44	6	781
Columbia	200	200	3,510
Fayette	50	26	886
Illmo	30	24	517
Kansas City	135	135	3,372
Marionville	24	12	449
Marshall	90	48	1,759
Maryville	110	50	2,074
Moberly	100	100	1,900
Neosho	80	50	1,484
Richmond	62	34	1,077
St. Louis	60	60	1,048
Slater	40	24	714
Springfield	314	314	5,934
Wardell	14	4	303
Webb City	70	70	1,026
Total, Missouri	1,563	1,237	29,540
Montana: Anaconda	40	40	$699
Nebraska:			
Ansley	20	20	323
Bridgeport	20	20	304
Beemer Village	20	20	319
Coleridge	10	10	171
Columbus	100	100	1,434
Fremont	132	132	2,086
Frontier County	24	20	363
Gordon	26	20	419
Oakland	28	28	401
Ravenna	20	20	306
St. Edward	20	20	317
Wayne	38	38	594
Total, Nebraska	458	448	7,037
New Hampshire:			
Concord [1]	25	8	549
Laconia [1]	24	24	652
Manchester	99	99	2,101
Nashua	100	100	1,890
Portsmouth	137	137	2,517
Total, New Hampshire	385	368	7,709
New Jersey:			
Bridgeton	200	150	4,192
Clementon Boro	70	70	1,433
Cliffside Park [1]	50	50	928
Dover	61	61	1,927
Freehold	48	48	952
Hoboken	200	200	4,114
Lakewood	106	106	2,111
Millville	110	110	2,225
Newark	500	378	11,551
Newton	100	80	2,274
Pleasantville	80	80	1,756
Trenton	59	59	1,021
Total, New Jersey	1,584	1,392	33,854
New Mexico:			
Alamogordo	150	50	2,537
Gallup	30	30	435
Tucumcari	90	40	1,507
Total, New Mexico	270	120	4,479
New York:			
Albany	195	195	4,349
Buffalo	24	24	431
Cohoes	100	100	1,842
Corina [1]	25	8	558
Cortland	90	90	1,580
Hempstead	476	476	10,927
Herkimer	75	75	1,606
Long Beach	192	192	4,141
Mt. Vernon [1]	200	50	4,536
Newark	60	60	1,202
New York	1,228	386	35,671
North Hempstead	104	104	2,213
Olean	81	81	1,223
Oneonta	112	112	2,290
Oyster Bay	213	231	4,472
Rochester	562	444	11,209
Rome	100	100	2,110
Syracuse [1]	306	200	6,481
Yonkers	140	140	3,317
Yonkers [1]	100	22	2,759
Total, New York	4,383	3,072	102,917

[1] Leased housing.

APPENDIX VII(2)—Continued

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED OCT. 1, 1969, THROUGH SEPT. 30, 1970 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
North Carolina:			
Albemarle	200	50	$3,757
Asheville	56	56	700
Beatie [1]	110	16	2,262
Chapel Hill	56	15	1,257
Clinton	100	30	1,812
Edenton	100	30	1,811
Elizabeth City	80	24	1,478
Farmville	150	36	2,808
Fayetteville	32	20	444
Gastonia	100	100	1,371
Greensboro	212	212	4,437
Greenville	17	3	335
Henderson County	52	52	888
Laurinburg	200	60	3,598
Lincolnton	150	50	2,900
Morganton	150	30	3,084
Murphy	40	10	822
North Wilkesboro	105	20	2,138
Oxford	200	50	4,007
Robersonville	50	16	827
Selma	75	50	1,465
Washington	46	38	677
Williamston	100	20	1,920
Total, North Carolina	2,381	988	44,798
North Dakota:			
Devils Lake	53	53	817
Fasher [1]	6	6	104
Glen Ullin [1]	14	14	242
Hazen	20	14	315
Hebron	14	14	242
Mercer	20	14	332
Minot	221	221	3,435
Total, North Dakota	348	336	5,487
Ohio:			
Akron	5	5	77
Amherst	50	50	771
Canton	200	200	2,841
Cincinnati	200	200	3,259
Cleveland	1,197	1,101	22,220
Dayton	193	193	2,926
Steubenville [1]	100	100	1,620
Toledo	161	161	2,380
Warren	4	4	65
Youngstown	143	143	2,199
Total, Ohio	2,253	2,157	38,358
Oklahoma:			
Bokoshe (Choctaw Nation)	16	6	300
Broken Bow	40	10	703
Elk City	70	36	1,181
Granite	14	6	260
Hugo	126	14	2,159
Jay	40	20	697
Oklahoma City	20	20	372
Picher	40	20	688
Wister	24	16	435
Total, Oklahoma	390	148	6,795
Oregon:			
Hermiston	50	50	742
Jackson County [1]	200	15	3,927
Marion County [1]	200	77	4,065
Nehalem [1]	200	90	3,721
Portland	411	411	7,560
Total, Oregon	1,061	643	20,015
Pennsylvania:			
Allegheny County	99	99	$1,812
Altoona	108	108	2,014
Armstrong County	115	100	2,199
Bethlehem	150	150	3,010
Brownsville	50	50	1,000
Bucks County	200	80	4,057
Carbondale	1	1	20
Connellsville	100	100	1,839
Elk County	80	40	1,598
Hanover Township	149	149	2,622
Homestead	100	100	2,036
Irwin Boro	70	70	1,389
Jeannette	100	100	2,204
Jefferson County	81	81	1,545
Lewistown	100	60	2,124
Lock Haven	142	90	2,871
Meadville	62	62	1,218
Olyphant	30	30	489
Philadelphia	92	74	1,894
Pottstown	80	80	1,657
Reading	226	226	4,152
Ridgway	100	100	1,945
Scranton	101	101	2,311
Sunbury	252	124	5,305
Taylor	100	50	2,051
Wellsboro (Tioga County H.A.)	82	82	1,428
West Chester	97	50	1,921
Wilkinsburg	60	60	1,123
Total, Pennsylvania	2,927	2,417	57,925
Puerto Rico: San Juan	208	208	3,140
Rhode Island:			
Central Falls [1]	100	12	2,400
Cumberland	55	55	938
Newport [1]	50	15	1,175
Pawtucket	260	260	4,907
Providence	502	502	9,423
West Warwick	63	63	1,134
Woonsocket [1]	50	25	1,157
Total, Rhode Island	1,080	932	21,134
South Carolina:			
Beaufort	80	20	1,582
Charleston	200	200	3,767
Columbia [1]	175	14	3,734
Fairfax	40	8	683
Florence	200	56	3,523
Greenville	203	203	3,764
Greenwood	76	16	1,448
Lake City	160	60	3,059
Seneca	100	40	1,695
Total, South Carolina	1,234	617	23,255
South Dakota:			
Columbia	146	146	2,756
Hot Springs	100	100	1,595
Howard	24	24	365
Lake Andes	24	6	440
Lennox	30	30	455
Martin	36	20	639
Milbank [1]	40	40	701
Parker	28	28	437
Sioux Falls [1]	150	140	2,262
Wessington Springs	30	30	472
Total, South Dakota	608	564	10,122

[1] Leased housing.

APPENDIX VII(2)—Continued

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED OCT. 1, 1969, THROUGH SEPT. 30, 1970 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Tennessee:			
Athens	137	62	$2,601
Baxter	20	8	387
Bristol	3	3	51
Chattanooga	350	350	5,518
Crossville	71	16	1,424
Dayton	110	30	2,201
Decherd	40	12	821
Dickson	75	15	1,447
Dresden	40	20	636
Erwin	70	20	1,295
Jackson	151	151	2,224
Lafayette	30	8	577
LaFollette	166	86	3,140
Lawrenceburg	50	30	850
Livingston	12	2	208
Loudon	50	20	999
Martin	60	30	1,033
McKenzie	100	30	1,821
Memphis	438	438	7,530
Monterey	30	12	543
Oliver Springs	48	15	959
Paris	140	50	2,424
Portland	50	20	977
Ripley	84	40	1,385
Rogersville	16	6	327
Smithville	34	18	658
Sparta	80	30	1,603
Total, Tennessee	2,455	1,522	43,639
Texas:			
Anson	30	30	517
Bangs	20	20	340
Beckville	16	8	294
Bogata	16	16	249
Brenham	160	100	2,590
Bryson	32	12	544
Centerville	10	8	169
Coleman	132	120	2,090
Cooper	50	30	822
Corrigan	60	16	1,031
Corsicana	110	90	1,671
Cotulla	60	16	1,052
Crockett	100	30	1,643
Crowell	30	20	546
Dallas	184	183	3,442
Dawson	14	6	213
Deleon	34	34	506
Detroit	20	14	333
Diboll	90	90	1,524
Eagle Pass	200	100	3,430
Ferris	36	10	631
Grandfalls	16	2	290
Gand Saline	50	20	821
Groesbeck	40	20	685
Harlingen	1	1	17
Hearne	30	16	523
Hico	30	14	511
Huntington	30	16	510
Ingelside	26	10	426
Llano	50	36	899
Lometa	20	10	336
Lott	18	8	300
Marfa	56	40	920
Mart	32	16	502
Maud	16	16	271
Meridian	16	10	292
Mount Vernon	36	14	584
Munday	36	20	612
Naples	20	10	302
New Boston	50	50	738
New Braunfels	200	100	3,520
Nixon	10	10	172
Nocona	30	16	545
Pearsall	80	18	1,417
Pineland	32	32	420
Robert Lee	12	6	$181
San Antonio	219	219	3,890
San Benito	50	50	708
San Saba	40	20	748
Seagraves	20	6	376
Texarkana	130	130	2,036
Throckmorton	32	20	500
Van	30	12	489
Weslaco	100	100	1,697
Winters	46	30	758
Wortham	20	20	316
Total, Texas	3,028	2,071	50,943
Utah: Ogden [1]	250	75	6,146
Vermont:			
Brattleboro	72	72	1,229
Rutland	150	75	3,046
Vermont State [1]	400	30	9,547
Total, Vermont	622	177	13,822
Virgin Islands: St. Croix	100	100	1,722
Virginia:			
Bristol	50	50	869
Richmond	100	100	1,753
Roanoke	317	317	5,973
Total, Virginia	467	467	8,595
Washington:			
Aberdeen	70	70	1,349
Anacortes	50	50	887
King County	400	400	7,166
Seattle	964	907	18,121
Tacoma [1]	100	45	2,121
Vancouver	100	100	1,870
Total, Washington	1,684	1,572	31,514
West Virginia:			
Clarksburg	130	130	2,356
Huntington	205	205	3,959
Moundsville	105	105	1,900
Wheeling	311	311	5,602
Total, West Virginia	751	751	13,818
Wisconsin:			
Albany	33	33	532
Appleton	154	154	2,370
Clintonville	61	61	938
Green Bay	156	156	2,480
Greenwood	20	20	323
Lac Courte	29	4	607
Luck Village	20	20	308
Marinette	111	111	1,728
Mauston	45	45	695
Milwaukee	310	310	5,243
Mondovi	26	26	409
Oneida	20	5	456
Osceola	30	30	450
Prairie Du Chien	40	40	628
Rhinelander	50	50	761
Rice Lake	81	81	1,275
River Falls	76	41	1,189
Shell Lake	30	30	485
Wisconsin Rpaids	68	68	1,037
Total, Wisconsin	1,360	1,285	21,914
Wyoming: Rock Springs [1]	100	50	2,308
Grand total	62,370	43,513	1,174,099

[1] Leased housing.

APPENDIX VII(3)

ELDERLY HOUSING LOANS PROGRAM, SEC. 202; SUMMARY OF APPROVED PROJECTS FROM INCEPTION OF PROGRAM THROUGH DEC. 31, 1969

State	Number of projects	Number of units	Aggregate project cost
Total	333	45,198	$575,171,141
Alabama	3	598	8,120,000
Alaska			
Arizona	2	273	3,284,550
Arkansas	1	136	1,608,000
California	42	5,171	65,648,078
Colorado	10	936	10,727,476
Connecticut	6	764	10,307,974
Delaware	1	236	4,000,000
District of Columbia	2	300	4,325,000
Florida	29	5,529	68,375,038
Georgia	9	1,568	19,629,408
Hawaii	1	111	1,735,000
Idaho	1	65	814,000
Illinois	9	790	10,858,905
Indiana	5	315	4,030,744
Iowa	10	751	8,804,006
Kansas	3	282	3,745,000
Kentucky	1	143	1,961,900
Louisiana	3	417	5,377,220
Maine	3	123	1,618,000
Maryland	11	1,925	24,907,009
Massachusetts	11	1,827	24,762,000
Michigan	24	3,473	45,976,312
Minnesota	17	1,448	18,559,265
Mississippi	1	101	967,000
Missouri	7	1,188	14,374,604
Montana	6	462	$5,698,660
Nebraska	2	176	2,160,000
Nevada			
New Hampshire			
New Jersey	11	2,052	25,684,107
New Mexico	3	306	3,874,000
New York	6	905	11,824,000
North Carolina	1	158	1,790,000
North Dakota	3	158	1,652,595
Ohio	21	3,294	42,243,883
Oklahoma	4	400	4,462,044
Oregon	3	610	7,295,499
Pennsylvania	19	3,462	44,834,000
Rhode Island	1	117	1,746,000
South Carolina	1	216	2,920,000
South Dakota	4	158	1,795,745
Tennessee	4	619	7,428,657
Texas	6	843	8,915,034
Utah	2	334	4,321,000
Vermont			
Virginia	2	291	4,125,000
Washington	9	1,237	15,309,328
West Virginia	2	122	1,881,000
Wisconsin	2	145	2,157,000
Wyoming	5	302	3,672,600
Puerto Rico	4	361	4,872,500
Virgin Islands			

APPENDIX VII(4)

ELDERLY HOUSING LOANS PROGRAM, SEC. 202, APPROVED PROJECTS 8 MONTHS (JANUARY–AUGUST) 1790

State and city	Name of project applicant	Aggregate project cost	Number of units
January-August 1970 program total		$5,173,500	398
California: Santa Monica	S. M. Christian Towers	189,500	13
Maryland: Silver Spring	Montgomery County Revenue	2,600,000	187
Montana: Plentywood	Montana Pioneer Manor	122,000	10
Tennessee: Johnson City	Christian Home for Aged	962,000	88
Texas: San Angelo	Rio Concho Manor	1,300,000	100

APPENDIX VII(5)

MORTGAGES INSURED ON ELDERLY HOUSING PROJECTS UNDER SECS. 207 AND 231 THROUGH DECEMBER 1969

State	Projects	Units	Mortgage amount	State	Projects	Units	Mortgage amount
Alabama	1	80	$763,000	Nevada	2	394	$4,480,200
Alaska				New Hampshire	1	170	1,440,100
Arizona	18	4,504	51,064,629	New Jersey	3	621	7,559,200
Arkansas	2	139	1,446,000	New Mexico	1	60	787,000
California	52	9,498	125,081,268	New York	4	301	3,641,009
Colorado	22	2,146	24,529,387	North Carolina	2	264	1,350,000
Connecticut	5	535	8,654,600	North Dakota	2	95	1,127,330
Delaware	1	234	3,540,300	Ohio	10	1,553	18,981,900
District of Columbia	2	659	8,666,704	Oklahoma	3	261	3,479,800
Florida	15	4,097	50,327,859	Oregon	10	1,589	18,204,500
Georgia	1	48	436,800	Pennyslvania	2	442	5,902,300
Hawaii				Rhode Isalnd			
Idaho	1	32	311,000	South Carolina			
Illinois	7	1,067	12,525,334	South Dakota	3	122	1,030,300
Indiana	2	348	5,000,000	Tennessee	5	573	7,261,500
Iowa	5	474	4,926,100	Texas	24	3,703	44,941,784
Kansas	5	603	8,082,000	Utah	2	402	5,326,600
Kentucky	8	788	9,200,050	Vermont			
Louisiana	5	324	3,761,400	Virginia	2	384	6,358,400
Maine				Washington	9	1,685	20,653,200
Maryland				West Virginia			
Massachusetts	1	25	225,000	Wisconsin	8	524	5,424,507
Michigan	6	1,080	11,612,006	Wyoming			
Minnesota	13	824	9,969,400	Puerto Rico	2	258	3,243,400
Mississippi	2	331	3,855,100	Virgin Islands			
Missouri	5	944	12,928,769				
Montana	2	158	2,115,000	U.S. total	285	43,463	534,320,941
Nebraska	9	1,115	14,106,205				

APPENDIX VII(6)

COMMITMENTS ISSUED, JANUARY THROUGH AUGUST 1970, ON SEC. 231

State	City	Name of project	Units	Mortgage amount
Minnesota	Edina	Rembrandt of Edina	88	$1,306,900

APPENDIX VII(7)

MORTGAGES INSURED ON NURSING HOME PROJECTS UNDER SEC. 232 THROUGH DEC. 31, 1969

State	Projects	Beds	Mortgage amount	State	Projects	Beds	Mortgage amount
Alabama	9	819	$5,054,259	Nevada	3	214	$1,971,900
Alaska	1	100	1,601,000	New Hampshire	3	200	1,561,700
Arizona	5	350	1,825,300	New Jersey	44	4,666	43,170,270
Arkansas	3	318	1,825,800	New Mexico	2	100	678,500
California	48	4,140	29,545,881	New York	33	4,662	42,516,798
Colorado	8	1,015	6,079,100	North Carolina	2	193	1,310,800
Connecticut	16	1,557	10,542,368	North Dakota	1	71	653,500
Delaware	3	316	2,665,300	Ohio	30	2,846	22,142,963
District of Columbia	2	455	4,100,100	Oklahoma	9	644	3,231,100
Florida	36	3,471	22,509,687	Oregon	15	1,270	7,271,700
Georgia	22	2,250	15,454,300	Pennsylvania	19	2,131	16,343,243
Hawaii	2	224	1,774,200	Rhode Island	2	253	2,533,100
Idaho	7	500	2,349,343	South Carolina	13	894	5,948,900
Illinois	32	4,088	26,362,602	South Dakota	2	115	644,400
Indiana	11	856	5,452,700	Tennessee	18	1,401	9,280,900
Iowa	7	379	2,892,600	Texas	38	4,121	24,273,500
Kansas	6	420	2,515,329	Utah	8	679	3,952,900
Kentucky	13	1,034	5,771,949	Vermont	3	238	1,732,800
Louisiana	6	548	3,035,900	Virginia	7	773	5,444,600
Maine	4	252	1,445,400	Washington	16	1,753	11,615,156
Maryland	10	1,291	10,218,912	West Virginia	5	443	3,464,000
Massachusetts	15	1,209	11,434,163	Wisconsin	15	1,739	12,616,919
Michigan	43	3,553	24,651,253	Wyoming			
Minnesota	7	526	3,223,200	Puerto Rico	1	160	1,726,400
Mississippi	10	538	3,237,000	Virgin Islands			
Missouri	18	2,025	17,957,600				
Montana	5	380	2,455,500	U.S. total	652	63,130	455,926,826
Nebraska	14	950	5,860,031				

APPENDIX VII(8)

COMMITMENTS ISSUED JANUARY THROUGH AUGUST 1970 ON SEC. 232 NURSING HOME PROJECTS

State and city	Name of project	Number of beds	Mortgage amount
California:			
Bakersfield	Beverly Manor, Inc	99	$744,500
Concord	San Miguel Convalescent Hospital	200	1,434,800
Eureka	Cransda Convalescent Hospital	82	673,200
Hawthorne	Hawthorne Convalescent Manor	99	729,000
Montara	Coastside Convalescent Hospital	41	334,500
Palm Springs	Palm Springs Convalescent Center	99	730,700
Palo Alto	Los Altos Sanitarium Hospital	50	451,400
Richmond	Brookside Manor	71	555,600
Riverside	Riverside Manor Convalescent Home	120	902,400
Sacramento	Crestwood Convalescent Hospital of Sacramento	110	884,700
Salinas	Beverly Manor of Salinas	92	773,800
San Jose	Crestwood Convalescent Hospital of San Jose	174	1,305,300
Colorado:			
Holly	Retirement Manor, Inc	60	416,400
Monte Vista	Willowcrest Manor Nursing Home	50	389,500
Ordway	Crowley County Nursing Center	50	340,300
Connecticut: Rocky Hill	Rocky Hill Convalescent Home	120	1,078,400
Florida:			
Merritt Island	Merritt Manor Nursing Home	58	485,100
Tampa	Manhattan Convalescent Nursing Center, Inc	156	1,267,300
Georgia: Thomasville	Glen-More Home	60	439,600
Idaho: Kellogg	Shoshone Convalescent, Inc	67	754,000
Illinois:			
Chicago	Belmont Nursing Center	200	1,400,000
Do	Beverly Convalescent Center	300	2,323,600
Do	Byrn Mawr on the Lake	315	2,337,000
Do	Greenview Pavalion	160	1,154,400
Do	Peyton Nursing Home	108	788,700
Dwight	Tri-State Convalescent Center	92	775,500
Freeport	Crestview Manor, Inc	99	730,000
Do	Freeport Manor Nursing Home	109	808,900
Mount Vernon	Setzekorn Nursing Home, Inc	64	520,000
Niles	Regency Nursing Home	300	2,226,500
Roseville	La Moine Christian Nursing Home	62	689,100
Silvis	Illini Convalescent Home	96	666,000
Springfield	Rutledge Complex Center	150	1,559,200
Zion	Zion Nursing Home	194	1,309,500
Iowa:			
Allison	Allison Manor Nursing Home	52	412,800
Clinton	Wyndcrent, Inc	95	902,900
Dubuque	Tri-State Convalescent Center	92	1,000,000
Kentucky:			
Fulton	Haws Memorial Nursing Home	60	440,000
Louisville	The Parkway Extended Care Center, Inc	252	2,842,800
Louisiana: New Orleans	Magnolia Health Center	236	1,867,500
Maryland: Berlin	Berlin Nursing Home	33	228,600
Massachusetts:			
Haverhill	Union Mission Home, Inc	120	1,160,000
Webster	Fentresz Nursing Home	80	1,001,100
Mississippi:			
Aberdeen	Monroe County Medi-Center, Inc	60	457,900
Hattiesburg	Hattiesburg Medical Complex	120	930,600
Greenville	Autumn Leaves Nursing Home	60	437,200
Lucedale	George County Nursing Home	60	453,800
Mendenhall	Simpson City Medi Center	60	471,200
Monticello	Lawrence County Nursing Center	60	431,500
Missouri:			
Hannibal	Beth-Haven Nursing Home	60	563,600
Do	Windsor Estates of Hannibal	80	623,300
Nebraska: Lincoln	Village Manor Nursing Home	50	350,400

APPENDIX VII(8)

COMMITMENTS ISSUED JANUARY THROUGH AUGUST 1970 ON SEC. 232 NURSING HOME ROJECTS

State and city	Name of project	Number of beds	Mortgage amount
New Jersey:			
Bridgewater	Greenfield Nursing & Convalescent Center	162	$2,062,300
Cedar Grove	Ridgeview Convalescent Home	180	2,464,000
East Orange	East Orange Nursing Home	195	1,822,500
Green Brook Township	Greenbrook Manor Nursing Home	176	2,269,500
Mendham Borough	Holly Manor Nursing Home	116	1,198,600
Millington	Milltonia Nursing Convalescent Home	100	1,098,000
Newark	Branchbrook Crest Nursing Home, Inc	120	1,555,200
Do	The Newark House Nursing Home	420	5,194,900
New Milford	New Milford Nursing Home	227	3,064,500
Paramus	Dellridge Nursing Home	78	934,500
Perth Amboy	The Messing & Extended Care	250	3,195,000
Red Bank	Red Bank Medi-Center	103	1,023,000
New Mexico: Sante Fe	Granada De Santa Fe	43	276,500
New York:			
Boonville	Sunset Nursing Home	78	798,000
Guilderland	Guilderland Center Nursing Home	120	1,627,800
Minoa	Minoa Nursing Home	82	1,062,200
Port Jefferson Village	C. S. M. of Port Jefferson	120	1,537,200
North Carolina:			
Black Mountain	Highland Farms	60	521,300
Jacksonville	New River Nursing Home	80	656,100
Ohio:			
Kenton	Manor Extended Care Center, Inc	100	919,500
Mount Vernon	Country Court	60	665,200
Ripley	Ohio Valley Manor, Inc	50	470,000
Steubenville	Royal Pavilion	120	1,233,000
Oklahoma: Tulsa	Extended Care & Rehab Center	100	2,386,400
Pennsylvania:			
Bethlehem	Fountain Hill Nursing Home	190	2,266,400
Springfield Township	Greenbriar Nursing & Convalescent Center	125	1,290,000
South Carolina:			
Newberry	Newberry Convalescent Center, Inc	60	492,000
Sumter	Hampton Nursing Center	84	696,500
Tennessee:			
Louisville	Peninsula Psychiatric Center	60	1,199,500
Memphis	Neurological Treatment Center	60	768,100
Do	Tranquilare Nursing Home	84	1,297,100
Do	Whitehaven Nursing Home	70	544,000
Texas:			
Amarillo	Olsen Manor Extended Care Nursing Home	120	692,900
Houston	Manda Ann Convealescent Home	100	539,200
Lubbock	Maddax Medical Center	200	1,905,200
San Antonio	Morningside Manor Nursing Nome (addition No. 2)	100	600,000
Vermont:			
Berlin	Willowbrook Nursing Home	160	1,691,300
Virginia:			
Emporia	Emporia Manor Nursing Home	60	628,200
Richmond	East View Lodge	120	1,831,600
Do	Parham Road Nursing Home	120	1,397,100
Salem	Boulevard Nursing Home	115	1,239,200
West Virginia:			
Elkins	Nallie, Inc	100	1,086,200
Martinsburg	Norborne Nursing & Convalescent Home	88	1,014,400
Parkersburg	Chateau Park Nursing Home Convalescent Center	104	994,000
Wisconsin:			
Bayside	Bayside Nursing Home	260	1,900,000
Florence	Florence Meadows Park Nursing Home	74	521,400
Kenocha	Kenosha Woodstock Health Center	182	1,593,900
Milwaukee	Belair Convelescent Center	259	1,996,200
Do	Fond Du Lac Woodstock Health Center, Inc	100	842,200
Do	Regency Nursing Home, Inc	190	1,340,600
Racine	Lincoln Village Convelescent Hospital	120	1,007,000
Puerto Rico	Cupey Rajo Nursing Home	160	1,875,000
Total, projects		12,342	117,346,000

ITEM 4: DEPARTMENT OF LABOR

U.S. DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, January 12, 1971.

DEAR MR. CHAIRMAN: Please find enclosed the undated material which you requested for your committee's report entitled "Developments in Aging—1970."

The enclosure of your most recent report was very helpful. I hope you will find the information adequate.

Sincerely,

J. D. HODGSON,
Secretary of Labor.

[Enclosure]

A REPORT ON PARTICIPATION BY OLDER WORKERS IN MANPOWER TRAINING, OPERATION MAINSTREAM, AND THE SENIOR AIDE PROGRAM

The Manpower Administration has continued in its efforts to train older workers for jobs in industry and government when those jobs are within reach of their attainment. What has been attempted more is the use of older trained, unemployed, or retired persons to fill the positions of supervisors, counselors, and administrators in the manpower programs. It is found that older workers, especially indigenous ones, establish a rapport with the enrollee many times better than younger workers. Older workers generally establish good relationships with older enrollees or older people in the community. Operation Mainstream has been the program which provided the vehicle for older workers. Due to the fact that Mainstream was primarily relegated to rural and semirural areas, and that the exodus of younger people from those areas has been pronounced, we find that this program has provided a surer avenue to jobs for older persons.

Administered by the Department of Labor, Operation Mainstream operates under titles I–B and I–E of the Economic Opportunity Act of 1964, as amended. The House-approved level of funding for Operation Mainstream I–B during fiscal year 1971 is $38.8 million. An additional $5.9 million was transferred from the Kentucky concentrated employment program—Operation Mainstream. Title I–B operations are shared by the regional and national offices. The latter consists of six older worker contracts which follow the same guidelines as the regional Mainstream program with one exception: Whereas the minimum age requirement for regional Mainstream programs is 22 years with 40 percent of the enrollees 55 years and over, enrollees in nationally operated Mainstream programs must be 55 years and over.

Following are older worker projects shown with the amount of current contract funds. (National Mainstream contracts are not funded on a fiscal year basis; therefore, some funds are fiscal year 1970 and some are fiscal year 1971.)

Sponsor	Slots	Funds	Dates
National Council of Senior Citizens (NCSC)	1,148	$3,446,912	Apr. 15, 1970–Apr. 14, 1971.
National Council on the Aging (NCOA)	572	[1] 3,582,028	Feb. 15, 1968–June 30, 1971.
National Retired Teachers Association (NRTA)	353	739,011	Sept. 16, 1970–Sept. 15, 1971.
Green Thumb/Green Light	2,680	6,960,160	Aug. 1, 1970–July 31, 1971.
Virginia State	125	[1] 479,904	June 30, 1969–Mar. 31, 1971.
Total Action Against Poverty in Roanoke Valley	70	300,000	July 5, 1970–July 3, 1971.

[1] This figure includes total moneys allocated to the program since its inception.

1. National Farmers Union

Green Thumb.—In August 1970, Green Thumb began operating under a new contract. Two States, Texas and Montana, were added, bringing the total number of States operating Green Thumb programs to 17. Funding was expanded primarily to accommodate the addition of these two States.

Green Light.—This component still operates in 11 of the 17 Green Thumb States.

2. National Council on the Aging

The original contract was extended to run from July 1, 1970, through June 30, 1971. A new appropriation of $1,350,000 was added to unexpended funds.

The variety of job categories has been expanded, for example, in Bronx, N.Y., enrollees are working as bilingual aides in social security offices; and in Portland, Oreg., enrollees working as housing authority aides are assisting older persons on the waiting list in terms of reviewing prospective housing.

3. National Retired Teachers Association

This year NRTA added a teacher aide component to its program, increasing the slot level by 40. The additional slots were divided between Kansas City, Mo., and Louisville, Ky., where the two teacher aide programs are operating.

4. National Council of Senior Citizens

This program is continuing at approximately the same slot level as the previous year.

5. Virginia State

This program is continuing at the same slot level as the previous year. The original contract was extended from July 1, 1970, through March 31, 1971, by adding $160,947 to unexpended funds.

6. Total Action Against Poverty in Roanoke Valley

This program, which began operating this fiscal year, employs persons on the George Washington National Forest in eight counties in Virginia. Most of the work requires the development of trade skills, for example, carpentry, masonry, and plumbing. Typical training opportunities include: Recreation aides, forest aides, park maintenance foremen, plumbers, carpenters, masons, surveyors, painters, as well as clerical positions.

The impact made by the senior community service program is immeasurable in those areas where it was placed. The three purposes of the program have exceeded initial hopes. The purposes were: (1) To show the need for added financial support to unemployed or retired senior citizens; (2) to prove to the community that there did exist another manpower pool that often was more dependable and reliable than those it was presently tapping; and (3) that with the knowledge that they were again needed and wanted, the senior citizen could overcome some of the aging problems such as fear, loneliness, and melancholy.

In fiscal year 1970, the Department of Labor reprogramed $10,037,963 to operate 114 Operation Mainstream title I–E projects. The title I–E program was designed to be used as an economic tool to create 5,367 jobs in selected areas of recession or high unemployment. Workers are concentrated in small communities and rural areas where job opportunities and training resources are limited. The design provides for substantial inputs for training and supportive services in addition to work experience. Particular attention is given to job development and placement. Mainstream I–E programs are subject to the same guidelines as Mainstream I–B programs with some exceptions. Priority areas for a Mainstream I–E program are: (1) Nonstandard metropolitan statistical areas in States eligible under the supplemental training and employment program; (2) other relatively small areas with significant increases in unemployment as compared with a year ago; (3) small areas with significant cutbacks in local defense installations, or seriously impacted by closing of or reductions in defense facilities; and (4) Indian reservations that do not have Operation Mainstream projects.

Procedural differences are as follows: (1) Title I–E programs are of 6 months duration. Contract renewals beyond 6 months must be based on continued high unemployment rate for that area as compared to the previous year, and (2) participants are enrolled for 13-week periods with an option for one additional 13-week renewal.

In December 1970. $10 million in reprogramed funds was made available for the continuation of title I–E Operation Mainstream.

ITEM 5: FEDERAL TRADE COMMISSION

FEDERAL TRADE COMMISSION,
Washington, D.C., March 1, 1971.

DEAR SENATOR WILLIAMS: Pursuant to your request there is herewith enclosed the annual report of the Federal Trade Commission on its activities pertaining to the Aging for 1970.

We hope this information will be both informative and helpful in your report. If we can be of further assistance, please let us know.

Sincerely,

MILES W. KIRKPATRICK, *Chairman.*

[Enclosure]

Although all of the Commission's many and varied activities are of benefit, directly or indirectly, to the elderly, it is within the Bureau of Consumer Protection that a preponderance of direct consumer activities benefiting the aging consumer is found; therefore, the following report will place major emphasis on the accomplishments of that Bureau during the calendar year 1970.

The Federal Trade Commission was created by Congress in 1914 as an independent agency with broad powers to proceed in the public interest against unfair, deceptive, discriminatory or monopolistic practices in commerce. It is committed to the preservation of the American system of free enterprise which includes protecting all consumers. In consequence, a significant amount of its work does affect, benefit, or concern the aging consumer.

The elderly stand greatly in need of protection in the marketplace, not only because they usually have very limited sources of income, and consequently must get the greatest value for each purchasing dollar, but they are also members of an age group for whom many unfair, misrepresentative, and deceptive schemes and sales techniques are designed. Because they are growing older and are concerned about their future ability to take care of such basic needs as medical expenses, their mental state and emotions often render them receptive to advertising, displays, and techniques which capitalize on such emotions, to which younger consumers facing different circumstances, give little or no attention.

During calendar year 1970, the FTC either had underway or had commenced a number of activities which will favorably affect the older consumer. These will be discussed briefly within the next pages.

To protect all consumers, but with the elderly and the poor especially in mind, the FTC in 1970 mounted a nationwide consumer protection and education program. Not only was the Division of Consumer Information, Bureau of Consumer Protection, set into operation to prepare materials for distribution to consumers, but a consumer protection specialists program was also mounted. Following intensive training sessions at Washington Headquarters, 77 consumer protection specialists were sent into the FTC field offices to work for the consumer at the grassroots level by disseminating to consumers information that they should have available for informed buying.

Specialists studied businesses, industries and geographical sections where complaints were concentrated to learn whether the laws administered by the FTC have been violated, and if so, to gather evidence for necessary legal action. Stress was laid on discovering to what extent susceptible groups, including the elderly, were affected.

Specialists counseled consumer groups, among them senior citizen organizations, warning them of common deceptions and unethical business practices and outlining steps that citizens can take to report and help correct violations.

As another aspect of the consumer information program, a series of radio and television public service announcements were completed in 1970, designed to warn consumers of dubious practices in current use; included therein were warnings against false claims for over-the-counter drugs, credit abuses, and get-rich-quick schemes, which might be particularly attractive to older people.

Plans were laid in 1970 for the publication, beginning early in 1971, of a monthly newsletter, *Consumer Alert*. This publication will contain feature stories, news briefs, cartoons, and other informational pieces on subjects of consumer interests. As the articles contained therein will be intended for the nontechnical, nonlegal reader, the FTC hopes that the elderly will be significantly included in its readers. Special efforts will be made to reach this group.

During 1970, the staff of the Division of Consumer Information began the task of revising *Consumer Bulletins*, some of which are of direct and particular interest to the elderly. The revised bulletins pertain to mail order insurance, chinchilla breeding by amateurs, unordered merchandise, freezer meats, color television x-radiation, and franchising. Additionally, the information contained in each bulletin is being reduced to "Buyers' Guides", abbreviated handbill versions of the bulletins, thousands of which will be made available to consumers. New bulletins under study and in preparation in 1970 deal with such subjects as credit card accounts, personal loans, purchases by installment contract, home improvements on credit, and purchasing of homes on credit.

During 1970, the FTC received more than 10,000 written communications, usually in the nature of complaints, from consumers of all ages, but including a large number from the aging. Generally these complaints alleged acts of unfair com-

petition, deception, and misrepresentation. Every complaint was individually studied and responded to. Each was thereafter evaluated from several standpoints: (a) danger, public health or safety, (b) number of consumers adversely affected, (c) indications that a particular segment of the population such as the elderly was affected, and (d) the economic magnitude and the amount or degree of financial loss suffered by consumers. On the basis of this evaluation by the staff of such complaints, the Commission determines how and where its resources should be committed.

As a result of this evaluation, the Commission during 1970 entered into a number of product or service areas specifically shown to be economically important, or even vital to the elderly consumer. Action in any particular area might include in-depth studies, preliminary or formal investigations, formal litigation at the administrative or appeal levels, and guide or trade regulation rule hearings or proceedings. Truth-in-lending activities by the Commission were fully implemented in 1970. The tenacious enforcement of the truth-in-lending law which became effective in 1969 is particularly important to those who have retired and are living on a fixed income. Costly credit errors may rob many of a significant percentage of their noninflation dollar pension.

During 1970, the Commission increasingly concentrated on the use of the industry guidance function to cope with problems which, directly or indirectly, bear upon the financial problems of the elderly. It is anticipated that a substantive measure of relief will be afforded older citizens through the work of the Commission begun or finalized during the year.

Perhaps the most important work done in the enforcement phase of the Commission's industry guidance activities was the continuing effort to seek industry compliance with the trade practice rules for the hearing aid industry and the guides against deceptive advertising of guarantees. Realizing that our elderly population comprises a substantial portion of the purchasers of hearing aids, the Commission continued its efforts to obtain compliance with its rules in the hope of curtailing dishonest and unrealistic claims concerning the performance of hearing aids, the amount of relief from partial deafness that users can reasonably expect to be afforded, exhorbitant savings claims and the type of product performance and service which purchasers may logically expect as the result of guarantees given by manufactures with the product.

In addition, while product guarantees affect the entire purchasing public, efforts were made to seek appropriate compliance with the guides against deceptive advertising of guarantees with the full knowledge that the elderly, as well as the poor or impoverished, are hardest hit when manufacturers use supercharged and inflated guarantees in their advertising to lure buyers to their products, while failing to perform the repair and service so advertised.

The Commission also conducted hearings on proposed trade regulation rules relating to retail food store advertising and marketing practices which were concerned primarily with the unavailability of weekly advertised food "specials". Realizing that those living on limited incomes, especially the elderly whose finances are fixed by annuities or social security funds, are especially inclined to shop the weekly food advertisements in order to obtain the best buy for their food dollar, the Commission is seeking to prevent the problem of unavailability and insure that shoppers are able to obtain what they are offered.

In other areas which directly affect the pocketbooks of all consumers, the Commission sought to limit or do away with practices which, among others, can be unduly burdensome or unfair to senior citizens. A trade regulation rule was promulgated limiting the mailing of unsolicited credit cards, a practice which grew to immense proportions in the 1960's. Numerous complaints were received that such cards were stolen before reaching the intended recipient or that improper charges were being assessed against an account through incorrect billing. Again, many of those affected by the practices were living on fixed or limited incomes and included many of our older citizens. This rule was subsequently rescinded after the Congress enacted the substance of the rule into law.

As a direct consequence of its efforts concerning unsolicited credit cards and the many complaints relating to incorrect billings, the Commission announced that it was considering a proposed trade regulation rule relating to billing practices by credit card issuers. In its proposed form, the rule is intended to curtail many of the more abusive and unfair billing practices which arise, in large part, due to the increasing use of the computer in billing and the inability of those to whom credit is extended to contact creditors and protest improper or incorrect charges.

Initial action was taken on two other proposals during the year which, while not solely intended to protect the elderly in the marketplace, would undoubtedly have substantial effect on this group. The first involves a proposed trade regulation rule which seeks to provide a three day cooling-off period in door-to-door sales. This proposal was developed as a consequence of the growing numbers of complaints received by the Commission from persons who found themselves obligated to buy a wide variety of merchandise which had been sold to them in their homes and which, on sober reflection, many neither wanted nor understood they had obligated themselves to purchase. Based on the complaints received, the Commission staff believes the aging are a prime target for high-pressure sales tactics and therefore are in need of protection. Under the terms of the proposal, prospective purchasers would have three days within which to consider such sales before they would become final and, within that period of time, change their minds and cancel the sales agreement if they so desired.

Staff effort was also devoted to the development of a proposal intended to preserve buyers' claims and defenses in consumer installment sales. The Commission had previously entered a number of cease-and-desist orders relating to the commercial doctrine of holder-in-due-course involving installment sales contracts which had been negotiated by householders and others and which were subsequently hypothicated by sellers to various financial and lending institutions. When buyers would find that the merchandise which they had purchased was not as represented, damaged or did not properly perform, they were required to continue making payment under the terms of the installment sales contract now held by another, while at the same time attemping to locate and seek adjustment from the seller of the product.

Finally, proposals involving the problems of unordered and undelivered merchandise were considered and developed by the staff. The first problem, unordered merchandise, affected not only the senior element of the community, but as a group they were probably as vulnerable as any single element in view of their stability and the fact that older citizens tend to have a fixed residency at a single address for long, extended periods of time, thus being prime targets for the mailers of unordered merchandise. After development of a trade regulation rule on this subject, the Congress incorporated the substance of the rule into the Postal Reorganization Act of 1970, thereby bringing into law a virtual ban on unordered merchandise. The Commission subsequently abandoned rulemaking efforts in this area and announced that the statutory provisions enacted by Congress would be regarded as interpretive of § 5 of the Federal Trade Commission Act for purposes of dealing with such problems.

The companion problem of undelivered merchandise is one which, by its nature, directly affects large portions of the senior citizenry. Many of our older persons, because of a dimunition in their mobility, are inclined toward purchasing through mail order establishments rather than through conventional retail outlets in the suburban and downtown shopping areas. For some time, the Commission had received an increasing number of compliants concerning the failure of mail order sellers to deliver merchandise to consumers which they had previously ordered and, in the majority of instances, paid for prior to shipment. In view of the apparently widespread nature of this practice, the staff commenced a research project to develop proposals for a trade regulation rule to curtail the practice. At the close of the year, these proposals were still in the formulation stage and had not been presented to the Commission for consideration.

The Federal Trade Commission will continue its efforts to eliminate unfair and deceptive practices affecting all citizens including the elderly.

ITEM 6: FOOD AND DRUG ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
FOOD AND DRUG ADMINISTRATION,
Rockville, Md., January 14, 1971.

DEAR MR. CHAIRMAN: This is in further reply to your request of November 25, 1970, for a statement on activities of the Food and Drug Administration which protect elderly consumers for inclusion in your report "Developments in Aging—1970."

A statement covering such activities is enclosed. Please call upon us if you wish additional information or assistance.

Sincerely yours,

CHARLES C. EDWARDS, M.D.,
Commissioner of Food and Drugs.

[Enclosure]

STATEMENT OF FOOD AND DRUG ADMINISTRATION ACTIVITIES AFFECTING THE AGED

The Food and Drug Administration is a scientific, regulatory, law enforcement agency dedicated to the protection of consumers of all ages. Because, however, the older consumer has particular health and economic problems, certain FDA activities are of special importance to that age group. As major victims of chronic ailments, the elderly have always been the principal market for products to relieve them of their money, if not their symptoms. But older persons are also the largest consumers of legitimate medication—pointing up the critical importance to them of FDA programs to insure the quality, safety, and effectiveness of all drugs. Similarly, the safety, wholesomeness, and nutritional quality of foods are of great importance to the elderly.

DRUG EFFECTIVENESS PROGRAM

During 1970, FDA gave highest priority to its drug effectiveness program, designed to rid the U.S. market of hundreds of ineffective drugs and to rationalize therapeutic claims for thousands of others on the basis of substantial scientific evidence. In this project the agency is applying the results of a mass evaluation of drugs approved for safety, but not for effectiveness, prior to passage of the Drug Amendments of 1962.

Over 200 of the Nation's leading experts on drug therapy took part in this monumental study, conducted under contract with FDA by the National Academy of Sciences-National Research Council. By the end of 1969, the agency had received a total of 2,824 separate reports involving some 10,000 therapeutic claims for more than 4,300 formulations manufactured by 335 companies. Each required evaluation and decisions as to labeling changes or proceedings to halt the marketing of products rated as ineffective, about 7 percent of the total number.

The pharmaceutical industry, unwilling from the start to accept the verdict of the medical experts, particularly as to widely used and highly profitable drugs, challenged the FDA regulations in a dozen lawsuits. The suits attacked the agency's authority to issue the implementing regulations, the procedures followed, and the regulations themselves. Others contested the applicability of the law to pre-1962 drugs, which, it was contended, had ceased to be "new drugs" and were therefore exempt from meeting the standard of effectiveness.

A major break in the legal logjam occurred in February 1970, when a key case, *Upjohn* v. *Robert H. Finch, Secretary, etc.*, was decided in favor of the Government by the court of appeals, and the Supreme Court refused to stay the decision.

The case involved FDA's authority to halt the marketing of combination antibiotic drugs (specifically the Upjon Co.'s panalba products) because they had not been shown to be effective as fixed combinations.

In its decision of February 27, 1970, the Court held that FDA had additional information (the NAS–NRC reports) in 1969 which it did not have in 1956 when panalba was first certified as safe and effective. It agreed with FDA that the evidence submitted by the company, much of it "testimonial" in nature, did not reflect the results of "adequate and well-controlled investigations including clinical investigations." It held that commercial success ($30 million annual sales) and widespread acceptance by the medical profession (23,000 physicians prescribing it regularly) "do not, standing alone, meet the standards of substantial evidence."

Notwithstanding continued litigation, by the end of 1970 FDA had started proceedings to halt the marketing of more than 300 drug products which had been found to lack substantial evidence of effectiveness or to be unsafe because their risks outweighed their benefits.

INSURING DRUG QUALITY

The safety of drugs, as well as their effectiveness, depend greatly upon their quality. FDA's intensified drug inspection program, begun last year, continued to produce marked improvement in manufacturing practices. In this program, teams of specially trained inspectors remain in the plant until compliance is achieved. At the end of fiscal 1970, 197 such inspections had been completed and 72 were still in progress. A large share of FDA's available inspection force was committed to this effort. With generally good industry cooperation, hundreds of corrections were made in production and control practices. Nineteen court actions were started where firms did not comply, and 24 makers of prescription drugs went out of business because of inability to meet the strict requirements of FDA's good manufacturing practice regulations.

Total drug and therapeutic device cases filed in the Federal courts increased from 190 in fiscal 1969 to 295 in fiscal 1970. Voluntary recalls of defective or mislabeled drugs and devices increased from 735 in 1969 to 1,017 in 1970. The total of all recalls increased from 910 to 1,427.

Some recalls involved very large quantities. Nearly 40 million capsules of the antibiotic chlortetracycline, made by eight firms, were recalled when it was found that, although they passed the chemical tests for potency, they failed to produce the blood levels required for effectiveness.

A high proportion of drug recalls involved products used by elderly patients. A significant example of such consumer protection was the approximately 60 recalls of digoxin tablets, a potent and widely used heart regulator made by some 38 manufacturers. When an industrywide investigation disclosed dangerous variations in potency, FDA started a continuous sampling program in which all production lots from over 30 firms which had defective samples are being checked by the FDA Center for Drug Analysis at St. Louis before they are released for sale.

PROBLEMS OF BACTERIAL CONTAMINATION

Bacterial contamination of drugs, or foods, may be particularly dangerous to elderly, bedridden individuals.

FDA insisted on recalls of several creams and ointment widely used in nursing homes for bed sores and other skin conditions when *Pseudomonas* bacteria were found in one lot.

A hospital outbreak of *Pseudomonas* infections triggered a nationwide public warning and recall of catheter kits containing a nonsterile cleansing solution. Extensive checks on the effectiveness of this company's initial efforts showed that 57 percent of medical care facilities, primarily nursing homes, were unaware of the recall. A second public warning was issued and telegrams sent to all county medical societies and State health departments asking their help to disseminate the information. FDA field districts made a survey of sterile device manufacturers and found several who were using ineffective procedures and packaging. One firm recalled over 40,000 catheters and feeding tubes.

Risk of infection of debilitated persons prompted the recalling of a contaminated "antibacterial' hand scrub and body cleanser used in hospitals and nursing homes.

A similar recall involved a nonsterile lubricating jelly.

The importance of FDA's continuing national program to reduce the incidence of *Salmonella* contamination of foods was emphasized indirectly by the tragedy which struck the Gould Convalesarium, a Baltimore nursing home, in August 1970. Some 25 deaths of elderly patients were attributed to *S. enteritidis* infection in this outbreak. FDA's cooperation was offered to the State and city health authorities and the agency assisted by sampling and bacteriological testing of foods and other potential sources of the infection. FDA inspectors also followed up on out-of-State source of foods served in the home. All findings in the FDA's investigations were negative.

L-DOPA CLEARED FOR PARKINSON'S DISEASE

Probably the most important single FDA action affecting the elderly in 1970 was its approval of the new drug L-Dopa for the treatment of Parkinson's disease. There are about 1.5 million sufferers from Parkinsonism in the United States, most of them in the past-60 age group.

The approval of L-Dopa was unique in that the FDA permitted its release notwithstanding very serious hazards in its use. The benefits of the drug out-

weighed its risks. To minimize these risks, unusual steps were taken. To obtain information on long-term effects, the manufacturers were required and agreed to continue their research and their reporting of its results. A new FDA newsletter for practicing physicians explained the agency's action and the precautions to be taken in using L-Dopa. Finally, a press conference was held to answer lay press queries on this new medical achievement and its conditional release for marketing.

STUDY OF HEALTH PRACTICES AND OPINIONS

This project suggested by the Committee on Aging and sponsored by seven Government agencies, to study the susceptibility of consumers to health fallacies and misrepresentations, was completed as to data gathering and statistical tabulations. A final report, now in preparation, is expected to shed new light on the health practices and opinions of the American public in general, and of elderly consumers in particular.

ITEM 7: HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., February 10, 1971.

DEAR MR. CHAIRMAN: This is in reply to your letter of December 10, 1970 to Dr. Vernon E. Wilson, Administrator, Health Services and Mental Health Administration, for a report on program activities in Aging.

Enclosed is a report on these activities within the Health Services and Mental Health Administration. If we can be of any other assistance please call on us.

With kindest regards,

Sincerely,

ELLIOT L. RICHARDSON, *Secretary.*

[Enclosure]

PROGRAM ACTIVITIES IN AGING

The Health Services and Mental Health Administration under the direction of the Administrator, is responsible for providing leadership and direction to programs and activities designed to improve general health services and mental health programs for the total population, and for achieving the development of health care and maintenance systems that are adequately financed, comprehensive, interrelated, and responsive to the needs of individuals and families in all socio-economic and ethnic groups. Obviously, the elderly along with the rest of the population benefit from program activities geared to meeting the needs of all the people. However, special attention to the needs of the elderly is required for certain facets of physical and mental health services and programs. The multiplicity of illnesses which often occur in the same individual making treatment more complex, the lack of mobility which serves as a barrier to obtaining available health services and the onset of senility are but a few problems which require special consideration in organizing health programs for delivering services to and preparing health personnel to deal with the aged.

To provide a focal point for the many diverse efforts in health services for the aged, the position of Coordinator for Health of the Aging was established within one of HSMHA's major components, the Community Health Service, which is the organizational unit specifically involved in health aspects of Medicare and which has a particular concern with the delivery of health services to the aged. In addition, an outstanding authority in gerontology was appointed as Consultant to HSMHA for the upcoming White House Conference on Aging (WHCA). Working in concert with the Coordinator for Health of the Aging, the Consultant is responsible for planning and coordinating HSMHA activities for this conference.

An inter-agency Federal Secretariat for the Technical Committee on Health of the WHCA was created, with the Consultant serving as director. Also, a HSMHA Committee on Aging was formed to provide an additional resource for the Conference. It is anticipated that after the WHCA is over, both of these committees will continue to serve as effective mechanisms for exchange of information and coordination of efforts in development of health programs for the aged.

Particular attention to the problem of the aging is incorporated into the activities of a number of the major operating components within HSMHA:

Community Health Service.
National Institute of Mental Health.
National Center for Health Services Research and Development.
Regional Medical Programs Service.
Health Facilities Planning and Construction Service.
Indian Health Service.

The following sections of the report describe the activities of these programs in more detail.

COMMUNITY HEALTH SERVICE

To achieve the National objective of the highest level of health attainable for the total population, Congress enacted the "Partnership for Health" legislation in 1966. This Act, which was subsequently amended in 1967 and 1970, introduced the concept of comprehensive health planning as a means of determining health needs, establishing priorities and recommending appropriate courses of action.

The focus of this national health effort is the individual and his family living in his own community. This focus requires the cooperation of many agencies, institutions, health personnel and consumers, as well as that of Federal, State, and local governments.

The Community Health Service carries out its responsibilities under the "Partnership for Health" and its responsibility to provide professional support for the administration of Medicare through the program activities of four divisions: Comprehensive Health Planning, Health Standards, Health Care Services, and Health Resources. In general, they emphasize support for better organized and delivered health services; fostering comprehensive health planning on a Statewide and areawide basis; development and monitoring of medical care standards to insure the delivery of good quality health services in a safe environment; aiding in the improvement of health resources—especially through development of training programs, educational and informational materials for administrative, professional, and auxiliary health personnel as well as the general public.

In all of these activities, 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 emphasis placed on planning and delivery of 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.

COMPREHENSIVE HEALTH PLANNING

In enacting the Comprehensive Health Planning and Public Health Services Amendments of 1966, Public Law 89–749, the Congress declared: " . . . fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living . . ." and ". . . comprehensive health planning for health services, health manpower, and health facilities is essential at every level of government . . . ." The State and areawide health planning agencies established throughout the country are working toward that goal. Although planning activities are being carried out for all citizens, particular attention is being given to high-risk groups, including the aging and aged. Currently all States and Territories have comprehensive health planning agencies, and there are now areawide agencies established to provide comprehensive health planning services for more than 50 percent of the population.

Some examples of specific CHP activities directed toward these groups include the following:

A comprehensive health planning council (Dade County, Florida) in the South has established a Nursing Home Advisory Committee to carry out an in-depth analysis of the county-wide nursing home situation and has set up criteria for certification of need for construction of new homes. In addition the staff provides consultation to local groups involved in providing health services to the aged in the community.

A multi-county CHP agency in the north-east (CHIPS, Syracuse, N.Y.), through its Task Force on Long-Term Care, has carried out several studies relative to the needs of the aged and chronically ill. Some important findings in this study identified the need for new and innovative facilities and

services particularly directed to "those who have been outside the mainstream of health care—the elderly."

One program funded by the Administration on Aging is related to comprehensive health planning in that funds have been granted to the Community Service Council, Inc. in Birmingham, Alabama, which is the designated Comprehensive Health Planning Agency in that area. These funds are for the development of a comprehensive service delivery program for the aging, including social services, outreach services, volunteer training, assurance of health services, and various innovative approaches.

HEALTH STANDARDS

When Medicare was enacted in 1965, the Secretary of HEW was required to establish national requirements for a variety of providers of services to protect the health and safety of program beneficiaries. Prior to Medicare, little existed in the way of established professionally acceptable standards for some providers of services, and particularly for long-term care facilities, home health agencies, and independent laboratories. Qualifications required for many types of health care manpower were also inadequate to assure a safe level of quality of services. The Division of Health Standards, working with the Social Security Administration, was assigned principal responsibility for standard-setting and surveillance, and for other professional health aspects of Medicare of direct benefit to program beneficiaries.

The objective of the Division of Health Standards is the improvement of the health status of Medicare beneficiaries by assuring that the types, quality and quantity of services provided under the program are appropriate to patients' needs. Since the onset of this program, the effects of the standards, along with their continuous evaluation and revision, have been to promote the upgrading of individual institutions and agencies, to improve State licensure and certification programs, and to stimulate changes in national accreditation programs. In establishing standards and surveillance techniques for individual health care practitioners, problems of quality and accessibility have proved difficult. However, Medicare has helped to focus attention on problems of health manpower—from physicians to nurses aides—including their supply and adequate surveillance of the services they provide. Various techniques for assuring quality of services without unduly limiting supply are undergoing study and experimentation, and Medicare, through the Division of Health Standards, is in the forefront of these efforts.

The Division has instituted several ongoing programs to promote and maintain the quality of care provided to elderly persons. Chief among these are the joint SSA/CHS program reviews of State Medicare agencies, during which evaluation is made of the effectiveness of program policy and guidelines, and the manner in which these are administered in the States. Of more direct benefit to program beneficiaries is the Division's promotion of utilization review, through which physicians evaluate services provided to beneficiaries to determine that such services are reasonable and necessary, rendered in appropriate settings by qualified practitioners and other health professionals, and performed at the right time, in the right amounts. The main thrust of utilization review activities will be to increase the effectiveness of surveillance of quality and appropriateness of services, particularly in those institutions and agencies in which the concept of utilization review prior to Medicare was nonexistent. A principal and rewarding function of the Division's medical staff is to provide consultation to SSA on medical problems that arise, many of which are connected with review of the appropriateness of care provided to individual Medicare beneficiaries.

In all of these activities, the focus of the Division is the health and safety of Medicare's elderly beneficiaries. All of its operations, planning, and evaluations are directed specifically toward this focus.

HEALTH CARE SERVICES

The Division of Health Care Services promotes the development and utilization of improved methods of health services organization, delivery and financing at the community level in both urban and rural settings. A special concern is the development, support and evaluation of methods for organizing and financing group practice arrangements as a community health resource. Priority is

given to the delivery of services to groups with special health needs, such as the urban poor and rural poor including the migrant worker.

Approximately 39 family oriented ambulatory primary care projects have been funded, including 14 recently transferred from the Office of Economic Opportunity. These projects support more effective ways of delivery ambulatory health services to individuals of all ages who live within a project area.

Audiovisual services

During the year the film "Tell Me Where to Turn," produced by the Public Affairs Committee through a CHS project grant, was shown to large numbers of people in every State. This film presents profiles of several elderly individuals with major health problems. It also illustrates their difficulties in locating appropriate health and social services to carry out medical recommendations. Information and Referral Services are shown assisting these aged persons to find the services they need. At the same time citizens are stimulated to take appropriate action to develop additional needed community resources so that the aged person can remain in his own home and receive care.

"One Door," a CHS produced film about a group practice of medicine, illustrates the benefits a multi-specialty group practice can offer to elderly individuals in need of comprehensive health care. Released in 1969, the film is being shown frequently to groups of professional and lay people who are in a position to encourage the development of this type of health service delivery system.

HEALTH RESOURCES

The Division of Health Resources encourages, assists, and supports appropriate agencies and organizations in developing needed health care resources and increasing their capacity to provide for the delivery of quality effective services. Major emphasis during 1970 has been concentrated on the Health Facilities Survey Improvement Program which is designed to improve and standardize the performance of State and Federal personnel engaged in surveying and certifying health facilities for licensure and for participating in Medicare and Medicaid programs, with delivery of high quality care in health facilities as the ultimate objective.

Working with the Association of State and Territorial Health Officers, the Program assisted in the development and support of the National Association of Directors of Health Facility Licensure and Certification Programs. The purpose of the Association is the improvement of patient care through licensure and certification activities and improvement of coordination of health care programs among State and Federal agencies. Four committees were established by the Association to work on a number of problem areas during the past year: Health Facility Standards and Guidelines; Patterns of Care; Surveyor Functions, Qualifications and Training; and Utilization Review. The work of the Association has provided new direction, thought, ideas, and perspective toward improving patient care and the development of a true State and Federal partnership working together on the many old and new health care problems.

Recognizing the need for improving the quality of health facility surveys, the HFSIP developed the four-week Health Facility Surveyor Training Course. It is now being conducted at three universities, Tulane University, UCLA, and the University of New Hampshire. Seventy State and Federal personnel have completed the course, and by the end of 1971, it is expected that more than 400 students will have graduated. In addition, HFSIP is developing 12 different specialty courses designed to provide an in-depth understanding of the specialty areas normally found in all health facilities. These areas include dietary services, nursing services, medical records, etc. These courses will be conducted in each State and are to be attended by State surveyors, consultants and administrators of health services.

Through programs encouraging hospitals to mutually share needed services and to cooperate in centralized purchasing and other cost reduction methods, the Division's Hospital Branch has been sensitive to the quality and cost of hospital care available to older patients. Additionally, this Branch has been promoting improved care of the aging through better cooperation between hospitals and other kinds of health facilities as well as extension of hospital-based services to the general community.

The Nursing Home Branch continued during 1970 to direct its efforts toward improvement of health and social services of long-term care patients in nursing homes. Included were the following activities: staff support to the National

Advisory Council of Nursing Home Administration; staging of a series of regional conferences to stimulate and support higher education opportunities for long-term care facility administrators; development of a licensure examination for nursing home administrators, through a contract with the Professional Examination Service of the American Public Health Association (examination now being used by 31 States); development of a curriculum to upgrade the quality of the licensed practical nurse who serves as the charge nurse; and the revision and updating of the publication "A Guide to Nutrition and Food Service" for nursing homes and homes for the aged.

During 1970, the Home Health Branch emphasized improved quality of care and enhanced ability of Home Health Agencies to provide more comprehensive services with particular priority to those individuals over 65 years of age.

Community Health Service central and regional office personnel and representatives of Social Security Administration met for a Home Health Conference on the improvement of home health program activities. A series of workshops was started for directors of Home Health Agencies' personnel which centers on the needs and problems impeding delivery of service and fulfillment of Social Security Regulations regarding certified home health care agencies. A series of memoranda has been distributed to all certified Home Health Agencies and interested professional persons containing technical information about regulations that apply to providers of home health services.

PROFESSIONAL EDUCATION

In 1970, Volumes II and III of the four-volume series entitled "Working with Older People: A Guide to Practice" were released. Volume I, "The Practitioner and the Elderly," was first made available in 1966: since that time more than 35,000 copies have been distributed or sold, and the demand for this publication remains heavy. Volume II, is entitled "Biological, Psychological and Sociological Aspects of Aging," and Volume III, "The Aging Person: Needs and Services." Volume IV, "Clinical Aspects of Aging," is expected to become available in the early part of 1971.

According to reports, these Community Health Service publications, which contain a comprehensive body of knowledge in applied gerontology, are serving as valuable resource material in training and continuing education programs sponsored by medical organizations, schools of nursing and social work, and other organizations concerned with health of the aged. Particular emphasis is being placed on the use of this resource material in the development of orientation programs for the practicing physician, who is the key member of the health care 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 a specific symptom is the philosophy the Community Health Service is endeavoring to engender among physicians for patients of all ages.

The paucity of teaching programs in comprehensive health care is of particular importance to the aging and aged. For while this inadequacy adversely affects the health status of the total population, the impact is most severe among the aging and aged, the population segment most 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 during the past 5 years has negotiated contracts with 10 medical schools to develop "blueprints" for teaching the concept and methodology of the comprehensive management of patients. Five medical schools (University of Missouri, Tufts, Mt. Sinai, the University of Southern California and Baylor) have completed their "blueprints" and are in the process of implementing them. Two schools (Georgetown and Boston University) are completing their "blueprints," and three additional schools (University of Arizona, Tulane University and the University of Pennsylvania) are just getting started on this activity. As a result of this program, five medical schools have initiated curriculum changes to incorporate the teaching of the principles and methodology of comprehensive care, and one school (Baylor) has created a new Department of Community Medicine which is serving as a focal point for introducing the new curriculum.

Audiovisual material

For the sixth consecutive year, two films on health of the aging produced by the Public Health Service continue to be in great demand, according to the Na-

tional Audiovisual Medical Center in Atlanta, Georgia, which serves as distribution point for the films. "The Critical Decades" focuses on the need for health protection for individuals in their forties and fifties to ensure 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 approximately 1,000 organizations in 1970. 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.

National Institute of Mental Health

Persons over age 65 are an exceedingly high risk group insofar as mental health problems are concerned. In 1967, the rate of first admissions per 100,000 population to public mental hospitals was 156.6 for persons 65 and over, the highest rate of any age group, and comprised 17.5 percent of the total first admissions. The rate per 100,000 resident population in mental hospitals was 682.9 for persons 65 years of age or over, or approximately 30 percent of all State mental hospital residents. Despite this demonstrated need for mental health services, persons 65 and over comprised only 2.1 percent of those persons utilizing out-patient psychiatric services during 1967, or a rate of about 82.1 per 100,000 population, the lowest rate for all age groups. Death rates from suicides between 1900–1964 indicate that persons 65 years of age and over are by far the highest. Various studies have estimated that anywhere from 10 to 25 percent of the persons living in nursing homes and other facilities serving the aged have some degree of mental impairment.

The NIMH goal, which is to improve the mental health of the people of the United States, is presently met through programs which seek knowledge about mental health and mental illness, through research, the training of professional manpower to perform services which will sustain and improve the mental health of all persons, demonstrations in State mental hospitals of ways to improve care of mental patients and through the development of community mental health centers to both treat and improve the mental health of persons in the community.

The primary purpose of the Section on Mental Health of the Aging in the Division of Special Mental Health Programs is to coordinate programs for aging persons within NIMH and to act as an advocate for programs designed to improve and sustain the mental health of the aging. The Section has program responsibility for applied research projects concerning aging persons, acts as consultant to applicants in developing proposals which will carry out the aims of NIMH, and monitors funded applied research projects.

RESEARCH

During 1970, there were 28 active applied extramural research grants in which the major focus was on aging persons. Twenty-one other projects which were of some interest to mental health of aging persons were also active. These projects were in the Center for Studies of Crime and Delinquency, Center for Studies of Metropolitan Problems, Center for Studies of Suicide Prevention, Clinical, Behavioral Sciences, and Psychopharmacology Research Branches.

Recent final reports of applied research projects indicate that findings are being made by research investigators which should be of help in planning and developing services for the aging. The goal of one completed study was the development of services in public housing projects to make personal, neighborhood, and community resources, services, and facilities accessible to tenants 60 years of age and over through reaching out efforts and provision of information and referral and generally supportive efforts. The services were carried out by paraprofessionals under the supervision of a social worker. The findings indicate a clear need for this type of service to help poor, uninformed, and old persons cope with the complexities of urban life, with a multitude of agencies, a complicated transportation system, and the confusions and perplexities of bureaucracy. It also clearly indicated that mature persons, carefully screened and given in-service training and on-the-job supervision, can discharge circumscribed responsibilities with competence and relative independence. Results of this project have been widely disseminated throughout other governmental agencies.

Another project provided comprehensive care for suspected mentally ill aged persons through the services of a multi-disciplinary team. This care included diagnosis, planning, placement, and treatment utilizing a broad range of community resources. The sample included 100 persons 60 years of age and older, for whom a petition of commitment had been filed. It was found that though in previous years, 75 to 85 percent of such persons had been sent from the screening ward where this research took place to a State hospital, insofar as the group studied and served was concerned, only 23 percent went to a State psychiatric hospital.

New applied research studies funded for the first time in 1970 include one which is assessing the effects of services and programs offered by an older adult program in a community center to aged individuals who have undergone various types and degrees of role changes. Another project provides an intensive case finding and service program which will yield information about the life style, attitudes, and social functioning of low income, urban, black aged.

Ongoing studies during 1970 include a project concerned with developing and demonstrating improved methods of finding and serving impaired older persons in the community. Another project is studying the effects of a sheltered workshop for severely impaired brain syndrome patients residing in a home for the aged. Support is also being provided for various studies of housing for aged persons. Among these is one which investigates what specific type of housing arrangements the aged perceive as ideal.

HOSPITAL IMPROVEMENT PROGRAM

The Hospital Improvement Program was established in 1963 in order to help the States improve their hospital services to the mentally ill. In 1970, 20 projects of this Program were concerned with aged persons.

Most of these projects combined one or more of the following: reduction of the length of stay for aged patients in mental hospitals through placement in the community, the restorations of a greater degree of social or physical functioning, and the developing of more adequate means of screening the aged inpatient population.

TRAINING

Currently there is increased interest in stimulating projects to train new types of nonprofessional workers to either help care for those aged who are already mentally impaired or to preventive mental health problems in aging persons.

At present the major proportion of NIMH training funds concerned with aging is being used for teaching grants and trainee stipends at social work schools. In 1970, 17 universities had training grants in the field of aging; 14 of these were in schools of social work and one training grant each was for geropsychiatry, nursing, and psychology.

Social work traineeships

Social work schools consider themselves as graduating generalists in casework, community organization, or group work fields, and have a generic approach to the client. However, the NIMH stipends are given to trainees with career goals in aging who are being supervised in a setting where aging people are being served. The typical program for the social work student includes courses in social welfare policy and services, human behavior and social environment, and social work methods. Students may elect concentrations in social casework, social group work, or community organization or may, in some schools, undertake training in combined methods. Those interested in aging studies complete a field placement in an old-age institution, a family agency, a community center, a mental hospital, etc., where the primary emphasis is working with aging persons. Information concerning the availability of trainee stipends may be obtained from the schools of social work administering them.

Training in psychiatry

NIMH plans, administers, and coordinates a national program of training in the field of psychiatry. This support is given in collaboration with the Nation's training centers and includes grants made to medical schools, hospitals, and clinics approved for psychiatric residency in residency training, or research training in special areas. Many of the programs include some involvement with care of geriatric patients whom the resident will serve. A program that

NIMH is funding specifically for geriatric psychiatry is at the Duke University Medical School. It is a two-year residency for individuals who have completed three years of psychiatric residency. Training is given in five areas, and includes geropsychiatry, geriatrics, and social, physiological, and biological gerontology.

Training in psychiatric nursing

NIMH also has a program of support designed to expand and improve training in the field of psychiatric nursing. Grants are made for undergraduate training, and doctoral, graduate, and training in special areas. Applications for trainee support are made directly to the training institutions. Many NIMH training grants in the field of nursing include some aspects of caring for the geriatric patient, but the only NIMH-supported program specifically for geropsychiatric nursing is presently at the Duke University School of Nursing. This is a one-year program for nurses who already have a master's degree in psychiatric nursing, with the curriculum emphasizing the aging process and psychiatric disorders prevalent in old age.

Upgrading efficiency of mental health personnel

NIMH plans, administers and coordinates a program for inservice training, staff development, postgraduate education, and adult education to upgrade the efficiency of personnel currently employed in mental health agencies and other mental health allied personnel and citizen groups. Applications for funds to support continuing education programs may be made by any public or private nonprofit institution.

One continuing education project grant has been awarded to the Gerontology Center at the University of Southern California, to cover a multidisciplinary group of professionals including general medical practitioners, psychologists, psychiatrists, city planners, architects, etc. The program aims at overcoming the unorganized nature of information on mental health problems of the aging. It includes one or two-day intensive seminars, five-day colloquia, and two courses on aging and mental health, organized into a single discipline.

Another continuing education grant concerning the aging was given to the Gerontological Society to develop a program of education in gerontology and mental health. Its objectives are to improve and increase mental health services to the mentally ill elderly, apply the most relevant research data to practice, and stimulate and involve more professionals in conscious innovation of services to the elderly.

Hospital staff development grants

Hospital staff development grants are designed to improve the quality of care of patients in mental hospitals. In 1970, NIMH funded 6 such grants which concerned aged persons. The grants are used for inservice training for aides, semiprofessional and professional staff, and to meet identified treatment needs. Various kinds of training programs are supported, such as refresher and continuation training, and special training for staff who do the inservice training.

An example is the hospital staff development program at Cushing Hospital in Boston, which admits patients 65 years of age and older on a voluntary basis and where the average patient's age is 83. This program is directed chiefly at developing the sociotherapeutic potential of the entire hospital staff, with the ultimate goal, the remotivation and social activation of the geriatric patient. Employees are provided with necessary and systematic training to enable them to translate knowledge into more effective services to patients.

Research fellowships

Research fellowships have been given directly to qualified persons in all mental health and related disciplines for research training related to the problems of aged persons. Such applications by individuals for predoctoral, or special fellowships are made under faculty sponsorship.

COMMUNITY MENTAL HEALTH CENTERS

In view of the high vulnerability of the aged to mental impairment, much hope had been expressed that the community mental health centers would be of assistance in helping the aged sustain themselves in the community. However, with the myriad problems that the centers face in staffing and serving those who, in cost benefit terms, may yield a higher return; e.g., the man who can go back to work with psychiatric help and thereby support himself and family, as com-

pared with the aged person who may continue to need supportive help and care for the rest of his life, the actual investment of resources in staff has been limited.

The aged have obviously not been of priority to the centers as can be seen from the following report for 1968 from a representative selection of community mental health center admissions. Of the total number of persons served, the elderly comprised 7½ percent of those persons receiving 24-hour care, nearly 4 percent of patients receiving partial care, and over 3 percent in outpatient care. When such minimal utilization is compared with the demonstrated need among the elderly for mental health services, it is obvious that the aged are seriously underrepresented in use of community mental health centers. There are a few programs in the centers which give special attention to the aged.

The Section on Mental Health of the Aging in the Division of Special Mental Health Programs has made itself available for consultation to community mental health centers through the regions in order to attempt to raise the priority for care of the aged in the centers. However, in view of the financial pressures that the community mental health centers are feeling, it is doubtful that new developments for aging services can be hoped for in the near future.

HEALTH INSURANCE AND MEDICAL ASSISTANCE

The NIMH is concerned with the development and extension of mental health services for the aged through the health insurance and medical assistance programs, Titles 18 and 19 of P.L. 89–97. The primary goal is to make benefits for the mentally ill aged 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 are major concerns.

To assess the effect of the recent Federal legislation on the care of the mentally ill, a study was done of the utilization of the mental health facilities by the aged. Length of stay and other factors which affect utilization were reviewed to determine if the patterns of care are undergoing change. A study is underway of the types and availability of alternative methods of care for the geriatric long term patient usually found living in the public psychiatric institutions. The study includes an exploration of the elements of care that must be available to assist patients to remain in their home communities.

NIMH participated with Community Health Service and the Bureau of Health Insurance (SSA) in pilot studies of the enforcement of standards and the evaluation of quality of care being provided mental patients in both public and private institutions. In cooperation with these two organizations, NIMH undertook a thorough review of the certification of the psychiatric hospitals under Medicare. This has resulted in the involvement in planning for changes in the special psychiatric requirements as well as planning for indepth training programs for the State survey personnel.

Workshops have been held for regional office staff members assigned as regional office staff for Titles 18 and 19. Included in these sessions were central and regional office staff from Community Health Service and the Social and Rehabilitation Service. Resource materials have been distributed to both regional offices and State mental health offices concerning policies and standards of care.

PUBLICATIONS IN PROCESS

Work is under way on a publication to bring together all research carried out by NIMH in the decade of the sixties. This publication will include summaries of all research projects funded by NIMH in this 10-year period for which results have been published. The booklet will include a review of the research and findings, the implications of the results or services, as well as a section which will discuss what these results mean in terms of goals in research on aging to which NIMH should address itself. It is hoped that this will be utilized for the 1971 White House Conference on Aging. Also in preparation is a handbook about community mental health services for the aged to be prepared with the help of the Group for the Advancement of Psychiatry. In collaboration with the Hebrew Home and Hospital for the Aged, Riverdale, New York, a document dealing with the treatment of the institutionalized older person is being prepared for publication.

PROGRAMS FOR AGED PATIENTS AT SAINT ELIZABETHS HOSPITAL

Saint Elizabeths Hospital is a Federal hospital operated by the National Institute of Mental Health under the general umbrella of the National Center for Mental Health Services, Training and Research.

The hospital functions in close association with the training and research divisions of the Center. It is in the process of reducing its inpatient census and providing community-based services including the operation of a community mental health center for a certain segment of the District of Columbia. The hospital's bed capacity is approximately 3,900 and the average inpatient load for Fiscal Year 1970 was 4,330. On June 30, 1970 there were 3,866 patients in the hospital and 39 percent of this number were 65 years of age or older. In addition, at the end of the year there were 2,247 patients on leave from the hospital of which 14.1 percent were 65 years of age or older.

Patients are eligible for admission under the District of Columbia Hospitalization of the Mentally Ill Act, Title 21, Section 501, of the District of Columbia Code, certain Federal and D.C. Codes regarding criminal proceeding, and other Federal and district codes.

Over the past five years the admission rate has averaged 3,225. The admission rate for patients 65 and over appears to be steadily rising. Patients within the hospital reach their 65th birthdays at the rate of 140 each year.

As a part of the treatment and care philosophy, it is believed that every patient admitted to the hospital has the potential for improvement and should be helped toward health and the full development of his capacities. As a part of the total health care program, there is a complement of medical doctors, including psychiatrists, and employees in many allied medical and mental health fields. Also included in the hospital complex is a 480 bed general Medicine and Surgery Branch which includes a 192 bed Rehabilitation Medicine Building.

The outplacement rate of patients over the past five years has averaged approximately 2,356 per year. This number includes those having personal resources as well as those for whom public monies are provided. These patients fall into almost all age groups.

Patients 65 years of age or older may be classified in two separate and distinct groups: those patients admitted to the hospital after their 65th birthday and those who have grown old in the hospital. Because of the decrease in the number of elderly admitted to the hospital, it is now possible to intensify efforts to treat and rehabilitate those who have grown old in the hospital and to return them to the community.

One special effort directed to the older age patient was a recent nursing care project which introduced activity programs which resulted in an increase in the patients' personal competence in activities of daily living. Another special study of the older patient revealed that this group of patients should be integrated into the general patient population of the hospital by housing them in general wards on admission rather than segregating them in a special building for geriatric patients. This policy is being followed and found to be quite beneficial.

Recently a re-evaluation of each patient was carried out with particular emphasis on mental and physical status and potential for rehabilitation to the highest possible level of independent living and self-care. Those who can afford to do so are stimulated to go shopping for their own clothes, to regularly wear their own clothing, and to participate in the washing and ironing of their own clothing. Those who have inadequate funds, and are physically able to do so, go to the hospital warehouse to choose clothes which they are encouraged to care for. The gentlemen, who are able to do so, shave themselves. All capable patients are encouraged to perform some regular work assignment, i.e., folding towels, sewing on buttons, making beds, sweeping floors, stacking dishes, etc. Recently a church choir was developed which performs at the weekly services. This has contributed to an increase in the number of patients attending services. One of the recreational activities which is particularly enjoyed is the trip into the community. These trips vary according to the individuals who are involved in planning. Trips have been made to the theater, a museum with lunch in its cafeteria, a downtown restaurant for dinner, an amusement park, and to various historic locations.

The use of tranquilizing and antidepressant agents is as helpful with this group of patients as they are helpful with other groups of patients. In conjunction, the individual patient's needs are met by habit training programs, grooming programs, reorientation groups, remotivation groups, community planning groups, group therapy with nurse, social worker, or chaplain; and, where

indicated, a nursing assistant working with an individual patient, a one-to-one relationship with a nurse, and individual therapy by a psychiatrist.

At present, the geriatric patient who is admitted to Saint Elizabeths Hospital is assigned to an age-integrated ward which has an intensive treatment program. This ward is part of a hospital division which serves the catchment area of the city which encompasses the patient's community residence.

National Center for Health Services Research and Development

The bulk of research in the provision of health services for the aged is currently being supported through the National Center for Health Services Research and Development. Current efforts are directed at improving and extending health services on a community-wide basis, with priority given to development of services for the disadvantaged, with the elderly regarded as an important subgroup.

The National Center is supporting the creation, testing and demonstration of prototype community health services systems. At the same time, it is attempting to improve the components necessary for such systems through development of: new types of health services manpower to extend the effectiveness of doctors; new financing arrangements; ambulatory and inpatient health care programs designed to provide comprehensive services to all people; and inter-institutional arrangements to link doctors' offices, hospitals and other facilities and services for continuous care. In designing the components for ambulatory and inpatient care, special attention is being given to the comprehensive and continuous care of the chronically ill and the elderly. Similarly, in developing improved arrangements for financing patient care, the effects of removing or reducing the deductible and co-insurance features of Medicare and other insurance plans are undergoing study.

During FY 1970, 24 projects concerned with health of the aged were being supported by the National Center for Health Services Research and Development. Approximately a half million dollars from 1970 appropriations were expended for these projects. The following are examples of this research:

Production of a comprehensive State-by-State analysis of laws affecting facilities for the aged in the form of a written manual on Nursing Home Law, which it is contemplated, will be styled after the Hospital Law Manual, published by the Health Law Center.

A project to assist nursing homes to meet new challenges to changing conditions, to help them find their roles as satellite to hospitals and to assist them in becoming supporting facilities for rehabilitation centers for continuing patient care through the practice of active nursing care and activity programs of therapeutic value.

A study to provide information on the use of health resources by a group of males 80 years of age and over while covered by a moderate third-party payment health plan and then to describe the changes that occur in use of medical resources after the implementation of a comprehensive medical care program.

An examination of the amount and type of medical services used by four groups of persons aged 65 and over in 1965 and 1968, and to estimate the amount of medical care which may eventually be expected to be demanded by the aged as a whole under Medicare.

A study of the impact and an evaluation of the relative effectiveness of diagnostic-evaluation services and follow-through services to applicants to a long-term care facility, including a cross-sectional and longitudinal study of these applicants.

A review of the published literature and unpublished information about nursing homes and nursing home research with a view to defining research needs and possibilities.

An examination of the transition from a classification reimbursement system for nursing home care to a cost-plus system by contrasting the payment systems as these affect the level of patient care in order to reduce and control medical care costs to the aged.

Development and demonstration of improved methods of finding and reaching impaired older people and of serving their differential needs, using inter-agency coordinated approaches, in order to formulate a set of recommendations, based on evaluation, for the provision of protective services on a continuing basis.

Regional Medical Programs Service

Regional Medical Programs Service, through grants and contracts, seeks to assist the nation's health institutions and the health professions to improve the organizations of health resources and accessibility of care, and to enhance manpower capability at the community level within a framework of voluntary cooperative relationships, in order to improve the quality of care to individuals—especially those threatened by or suffering from heart disease, cancer, stroke and kidney disease, and other related conditions.

LEGISLATION

By the end of 1970, 54 of the 55 Regional Medical Programs were in operational status. More than three-fourths of them had been operational at least one year and five of these are in the fourth program period. The program was extended and amended (at the end of October 1970) with the enactment of P.L. 91–515—"Heart Disease, Cancer, Stroke and Kidney Disease Amendment of 1970." Significant changes in program scope are: specific mention of kidney disease and other related diseases, and prevention and rehabilitation through demonstrations. Additional emphasis is given to regionalization of health care resources and services in order to strengthen and improve primary care and the relationship to specialized care. Construction authority not to exceed $5 million per year is added, and multi-program service grants and contracts are expanded.

OPERATIONAL ACTIVITIES

During the year, funds were available to the 54 programs for the support of about 600 components activities with a specific categorical disease or comprehensive multiple-disease focus, involving continuing education and training activities, demonstrations of patient care, research and program development. Also of significance to community services and with potential beneficial impact for the aging is the newly emerging relationship with the Model Cities programs of the Department of Housing and Urban Development. The program was established as a demonstration of new ways in which Federal, State and local cooperation and funds can make a substantial impact on the physical and social problems of the city. HSMHA has taken steps to improve coordination of its health planning and program development functions involved in this concern with the Model Cities programs. In this fiscal year nearly $2 million in RMP grant funds have been earmarked for grant awards for model cities-related activities. These awards are made specifically for impact upon the model neighborhoods so as to improve the quality of health of the residents.

Most of the disease-oriented activities are not directed solely at the aging or the aged. Nevertheless, efforts aimed at improvement of care for the aging and lessening the impact of chronic long-term illnesses are appearing in a number of patient care demonstration activities and training such as: home health care, training and follow-up, rehabilitation, especially for older patients following a cerebrovascular accident, multiphasic screening and prevention, cardiovascular and pulmonary disease-oriented demonstrations, public education programs, and nutritional activities.

Typical activities being supported by the Regions, which involve services for the aging and which are impacting on their health are cited in the brief descriptions which follow.

SCREENING

In California two multiphasic screening programs were funded recently. In East Palo Alto the Neighborhood Health Center will sponsor the multiphasic health testing project which is receiving support from the RMP for consultation services from Stanford Medical School on clinical aspects and from the San Mateo County Department of Public Health.

The multiphasic screening program for the poor in San Joaquin Valley (California) is being sponsored by the County Medical Society which will contract with Health Facilities Foundation to conduct the project. The purpose is to identify health needs and determine the extent and type of conditions requiring medical care, as well as demonstrate that *mobile* multiphasic screening can be linked between health needs and health services in a poverty community.

Multiphasic screening activities, not all equally broad in scope but which reach a total community, are being supported in several other regions as well. Some screening projects are limited to a specific disease or related condition, but often include the aging as in the case of hypertension screening.

REHABILITATION

Rehabilitation activities are associated with the majority of stroke demonstration projects. Some have as a primary purpose training and education of health professionals in the field of rehabilitation which indirectly will benefit the aging. Others include training of home health aides and other allied health workers for care of patients at home or in a nursing home, and consultation services. Illustrative of these is the community-oriented continuing education project in stroke rehabilitation in Wisconsin. This aspect is one phase of a comprehensive stroke program. In selected non-urban areas, primary emphasis is given consultation services and postgraduate educational programs for physicians, nurses and allied health personnel.

DEMONSTRATION ACTIVITIES

Home health aide projects are directed at training of health workers and family members to care for chronically ill long-term patients with heart disease, cancer and stroke. Some of these activities are coordinated with the visiting nurses association; others involve public health nursing organizations and follow-up services after discharge from community hospitals.

Practically every region is supporting a demonstration or continuing education project involving patients with cardiovascular disease. Some are based at community hospital coronary care units; others offer education and training courses at the medical center, and consultation services in smaller peripheral hospitals.

Funds are available to a number of regions for developing comprehensive pulmonary care programs, including correlated educational activities. Some emphasize care for patients with emphysema and chronic respiratory disease in extended care facilities, and others are developmental.

Although not specifically identified for the aging, several RMP projects have been cooperatively funded with a model cities program in conjunction with Neighborhood Health Centers, such as those efforts in St. Louis and Kansas City, Missouri, Salt Lake City, Utah, and Tampa, Florida. In New Jersey urban health coordinators supported by RMP are working closely with citizen groups in developing health components of model cities plans.

Health Facilities Planning and Construction Service

A primary objective of the Health Facilities Planning and Construction Service, which administers the Hill-Burton Program, is to stimulate the construction of facilities needed to bring about an efficient, well-coordinated network of services for the acute care, long-term, and rehabilitation of all persons, including the aged and aging. As of July 1, 1970, the Hill-Burton program has provided assistance for the construction of 93,749 long-term care beds in chronic disease hospitals, nursing homes, and units of general hospitals.

The need for construction of long-term care facilities continues at a high level. As the aging population continues to increase, the demand for adequate nursing home care for them must be met. In addition, the enactment of the Medicare program partially removes the economic barriers to care of the aged. State agencies report that 419,000 long-term care beds, including extended care facility beds, must be constructed, remodeled, or replaced. In FY 1970, 63.6 million dollars were appropriated for the construction of long-term care facilities. This level of financial assistance will stimulate the construction of approximately 8,900 long-term care beds.

The aging and aged will benefit also from the construction or modernization of other health facilities under the Hill-Burton program. Hospitals, diagnostic and treatment centers, public health centers, and rehabilitation facilities are used extensively by the aging. Funds appropriated for these facilities totaled $108.6 million in 1970.

In addition, the following services provided by the Hill-Burton program contribute to improved health care of the aged and others throughout the Nation: (1) technical and professional consultation regarding all aspects of facility planning, design, and construction, which is available to States, public agencies,

and nonprofit organizations; and (2) guide material relating to the planning, design, equipping, and construction of health facilities, which is continually being developed and distributed.

INDIAN HEALTH SERVICE

The Indian Health Service has statutory responsibility to provide comprehensive health services to all of the reservation Indian and Alaska Native population. It is estimated that approximately 60 to 70 percent of the identified needs of these approximately 415,000 persons are now being met. Indians and Alaska Natives are a young population with approximately 5 percent aged 65 and over, and about 12 percent aged 45 to 65. Indian and Alaska Native aging and aged persons are reached through IHS health activities focused upon the family constellation and upon Indian and Alaska Native communities.

The special attention of the IHS health team to preventive health care combined with early identification of disease and health related problems has favorably affected the life span of the Indian and Alaska Native. Life expectancy of the Indian and Alaska Native in 1960 was 61.7 years and in 1967 was 64 years as compared with the U.S. all races totals of 69.7 and 70.5 for those same years.

Federal and State services which are available to all other citizens are utilized along with IHS health care programs in order to more readily advance the health status of the Indian and Alaska Native people. Such services as available for the aged are coordinated with the IHS program in meeting the needs of the individual aged Indian person.

ITEM 8: INTERNAL REVENUE SERVICE

JANUARY 5, 1971.

DEAR SENATOR WILLIAMS: Enclosed is a brief report on IRS programs and activities conducted on behalf of older Americans. Your consideration to include this report in "Developments in Aging—1970" is greatly appreciated.

We feel these programs to assist the elderly with their unique tax problems and situations are very important, and I can assure you that they will continue to play an increasing role in our efforts to improve our service to the public.

I am enclosing two copies of each of our publications for elderly taxpayers as you requested.*

Please feel free to contact me if I can be of further assistance.

With kind regards,

Sincerely,

RANDOLPH W. THROWER,
Commissioner.

[Enclosure]

INTERNAL REVENUE SERVICE ACTIVITIES AFFECTING THE AGED

Two areas in which the Internal Revenue Service has attempted to improve its service to elderly taxpayers during 1970 are: (1) improvements in the form 1040; and (2) increases in the amounts and types of taxpayer assistance training provided.

CHANGES IN FORM 1040

The consolidated form 1040 introduced last year will be continued for 1970. Although returns up to $5,000 declined by 1 million in 1969, our statistics show that 1 million more returns in that category included itemized deductions for the first time. However, several changes have been made in the form 1040 which should be of particular aid to the elderly in preparing their income tax returns for 1970.

This year Internal Revenue Service will compute the 1970 income tax for persons with incomes up to $20,000 provided they take the standard deduction and all income is from salary, wages, dividends, interest, pensions, and annuities.

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*Retained in committee files.

Formerly this was done under much more restrictive circumstances for taxpayers with incomes under $5,000. The new rules include pension and annuity income for the first time so that the elderly can take advantage of the offer. In the typical situation, taxpayers need only enter the information that they alone would have knowledge of, such as income and tax withheld. IRS will then compute the tax and refund any overpayment or render a bill for any additional tax due.

Of equal importance to the elderly, IRS will also compute the retirement income credit to which the taxpayer is entitled. This dual IRS computation of the tax and the retirement income credit will eliminate two of the most difficult areas that elderly taxpayers encounter.

The procedure for those who prefer to compute their own tax has also been simplified. The separate tax computation schedule (schedule T) has been eliminated and the computation revised so that taxpayers should have little difficulty. In addition, the retirement income credit schedule has been redesigned to enable most taxpayers to bypass consideration of credits for foreign taxes and tax-free covenant bonds, two items that were causing confusion and difficulty for some elderly taxpayers in computing their credit.

There have been other changes in the design of the forms which taxpayers felt would be helpful. For example, instructions have been moved from the backs of schedules and consolidated in the center of the tax package. Of particular interest to the retired and elderly, the retirement income credit schedule will be printed on the back of the annuity and rental income schedule.

TAXPAYER ASSISTANCE TRAINING

Last year the Internal Revenue Service began a nationwide program to provide taxpayer assistance training for the elderly. Through this institute program, volunteer representatives of various retirement and elderly organizations receive training in the preparation and filing of Federal income tax returns and then serve as assistors to other members of their organizations in meeting tax filing requirements. In the training, the provisions of the law that apply specifically to elderly and retired people are stressed.

During the last filing period, IRS conducted 19 institutes specifically for the elderly and retired, with more than 550 volunteers given an average of 8 hours of tax training. As a result of one institute conducted in San Francisco, the 24 volunteers participating reported assisting 485 elderly taxpayers with their returns. Based on this year's successful experience with the program and with greater involvement on the part of interested retirement organizations such as the American Association of Retired Persons, the National Retired Teachers' Association, and the National Association of Retired Civil Employees, IRS plans an expanded program for the elderly for the 1971 filing period. As an example of greater involvement by retirement groups, the Institutes of Lifetime Learning (a service organization for various retirement associations) has appointed regional training coordinators in 10 major cities throughout the country. These coordinators will be responsible for contacting retirement groups in their areas to inform them of the elderly tax assistance program. They will also ask for representatives to receive training so that they can serve as assistors.

In addition to this institute program, IRS offices conducted 44 retirement counseling sessions for the newly retired or those planning to retire. These sessions ranged in length from 1 to 4 hours and were attended by over 3,200 persons.

In an effort to help Federal employees better adjust to retirement years, IRS developed for the Civil Service Commission a preretirement counseling program on "The Federal Income Tax Implications of Civil Service Retirement." This program, designed to be offered by agency retirement counselors, will be made available to all Federal departments and offices.

Documents related to these training and counseling programs for the retired and elderly are also provided by IRS. They include among others, publication 554, Tax Benefits for Older Americans; publication 524, Retirement Income and Retirement Income Credit; and publication 568, Federal Tax Information for Civil Service Retirees. Copies of these and similar publications are available free of charge from IRS district offices and major subordinate offices.

ITEM 9: NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
Bethesda, Md., January 8, 1971.

DEAR MR. CHAIRMAN: A report on the support and conduct of research on aging by the National Institute of Child Health and Human Development is enclosed for inclusion in "Developments in Aging."

It is a pleasure to supply you with this material.

Sincerely yours,

GERALD D. LAVECK, M.D.,
Director, National Institute of Child Health and Human Development.

[Enclosure]

THE NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (NICHD)

Ten percent of the U.S. population is older than 65 years, and 80 percent of those over 65 have one or more serious diseases. Two-thirds of the Federal money spent on health care in this country is spent on persons over 65. One million persons over 65 live in institutions. It is clear that the health problems of the older person in this country are of major importance.

Environmental and genetic factors are important in the diseases of older persons, but major factors in the origin of those diseases are aging processes themselves. Thus the National Institutes of Health (NIH) supports research on aging processes as they relate to health. It carries out this part of its mission through one of its components—the National Institute of Child Health and Human Development (NICHD).

NICHD supports extramural research on aging by scientists at universities, hospitals, research institutions, and industry through its Adult Development and Aging Branch; and it runs an Adult Development and Aging Information Center through its Scientific Information Centers Branch. The institute conducts an intramural program of research on aging at its own research facility—the Gerontology Research Center in Baltimore.

EXTRAMURAL RESEARCH PROGRAMS

Aging and chronic diseases

Aging processes are causative factors in a great many older persons' diseases—atherosclerosis, cancer, osteoporosis, osteoarthritis, senile dementia, cataracts, and others. These are multifactorial diseases, the outcome of genetic background, environmental agents, and aging processes. Progress in preventing and treating them depends in part on understanding the nature of aging processes and the causative roles they play in diseases.

To focus attention on this topic. NICHD supported a conference at the University of Washington School of Medicine in Seattle at which the relations of aging processes to chronic diseases were explored. Particular attention was given to atherosclerosis, osteoporosis, and decay in immunological competence with age. The conference was attended by clinical investigators from many university medical schools.

One major approach to the problem of aging and chronic disease is through the use of longitudinal studies—studies in which the same individuals are examined repeatedly over a period of years. Most of the present knowledge concerning changes with age has accrued from cross-sectional studies in which individuals from different age groups are examined at the same time. These are handicapped by the fact that persons from different age groups have different backgrounds since pertinent factors such as nutrition have changed in this country in the last 100 years. Thus, it is difficult to tell from cross-sectional studies whether a change in a human characteristic is due to intrinsic aging or to environmental forces and changes in life styles. Age differences in intelligence, for example, could derive from intrinsic aging, environmental forces acting over time to damage the brain, or, in part, from entirely different backgrounds of intellectual activity in persons from different age groups.

Longitudinal studies avoid some of these difficulties, but they are difficult. The long periods of time involved produce problems of continuity of subjects,

investigators, and methodology and make for high costs. The studies, therefore, require extremely careful planning if they are to be successful.

In 1966, the House Committee on Government Operations recommended that NIH, in cooperation with other Government agencies, review Government-supported medical research on aging, particularly long-term studies. NICHD coordinated this review and a report was submitted to the committee in 1970. It covers longitudinal studies of medical research on aging and programs of medical research on aging supported by Government agencies in fiscal year 1967.

The report reviewed 15 longitudinal studies support by NIH, the National Institute of Mental Health, the Veterans' Administration, the Atomic Energy Commission, the Navy, the Air Force, and the Federal Aviation Administration. The research programs reviewed were those of NIH, the Health Services and Mental Health Administration, the National Institute of Mental Health, the Veterans Administration, and the Atomic Energy Commission. The report can be obtained by writing NICHD.

In April 1970, the Institute sponsored a conference on longitudinal studies attended by representatives of the Air Force, Army, Navy, Atomic Energy Commission, Federal Aviation Administration, Veterans Administration, National Heart and Lung Institute, Social Security Administration, National Institute of Mental Health, and the National Center for Health Statistics. Representatives of some university-based longitudinal studies were also present. The conference dealt with means for improving interactions between the various groups conducting longitudinal studies on aging and chronic disease.

Aging and mental function

The changes that occur in mental function with age are complex, and knowledge about them is incomplete. There is evidence of relatively mild impairment that begins as early as the middle years and, no doubt, becomes more severe in old age. The elderly may also have chronic brain syndromes characterized by disorientation, confusion, and loss of recent memory. Whether or not some chronic brain syndromes are due to the same processes that produce mild loss of function in the middle years is not known.

Some of the chronic brain syndromes of the elderly are due to cerebral atherosclerosis; others are associated with the neuronal changes and neurofibrillary plaques described by Alzheimer and occurring in both presenile and senile dementia.

Chronic brain syndromes are common and very disabling in the elderly. They cause severe loss of mental function in about half of the 1 million old persons institutionalized in the United States. There is some evidence that about 6 percent of the noninstitutionalized elderly have severe mental impairment due to chronic brain syndromes.

NICHD supports research on the changes in mental function occurring in the latter part of life. Several interesting studies were started to follow up recent short-term observations showing that breathing high concentrations of oxygen under increased pressure will improve thought processes of elderly patients with mental deterioration.

Biology and aging

An understanding of biological aging processes that contribute to the development of diseases is needed to provide a base from which to attack chronic diseases of middle and old age.

To encourage research in this area, NICHD currently supports a summer course in the biology of aging designed to give an overview of biological aging and a detailed analysis of selected topics. The course was held at the University of California at San Diego in 1969, taught by a faculty of scientists from many universities, and attended by 20 pre- and post-doctoral students. In fiscal year 1971 it will be held at Stanford University.

Important aging processes occur at the cellular level. The Institute in fiscal year 1970 continued to encourage the development of research on cellular aging. Plans were made for the support of a summer workshop on cellular aging at the W. Alton Jones Cell Science Center at Lake Placid, N.Y. Selected topics in cellular aging will be discussed, and there will be opportunities for laboratory experience in vitro techniques and other methods important in the study of cellular aging.

Aging in the entire organism is complex. Changes occur within individual cells and in the extracellular matrix in which they lie. Culture of isolated cell types may make possible an analysis of aging in a simplified system.

One lead in this area is the observation made in the last decade that normal fibroblasts do not live indefinitely when grown by current methods. Fibroblasts are cells that produce collagen, the protein present in greatest amount in the human body.

Observations in this area are complicated by the fact that fibroblasts in tissue culture can undergo genetic changes that make them immortal. However, they can then no longer be considered normal cells. The change is similar to the change that occurs when normal cells become malignant.

An understanding of the failure of human fibroblasts to live indefinitely in vitro is important to our understanding of aging. Future studies may reveal that improved methodology will permit indefinite growth of fibroblasts, or that there are fundamental reasons why normal cells are not immortal in tissue culture. Either discovery would clarify our understanding of cellular aging.

NICHD supports the production and distribution of a line of human fibroblasts (WI–38) to interested investigators. These cells are grown to various stages in their in vitro lifespan and then stored frozen at subzero temperatures. The central supply of such well-characterized cells facilitates work in this area by reducing the work of individual investigators and by assuring that different investigators are working on the same cell types.

Another promising subject for study is the molecular material containing the information that directs cellular activities—deoxyribonucleic acid (DNA) ribonucleic acid (RNA), and related components of the system governing the synthesis of protein in cells. To give interested investigators an opportunity to discuss their research in this field, NICHD supported a conference on molecular biology and aging at the University of Miami. Plans were made for the attendance of a small number of scientists interested in the molecular biology of aging at National Science Foundation molecular biology workshops which meet at the University of California at San Diego. The Institute supports training grants in the molecular biology of aging in the Biology Department of the Johns Hopkins University, and in the Biochemistry Department of the Boston University School of Medicine.

A major problem in studying aging has been the difficulty of acquiring suitable experimental animals, a problem NICHD is attacking systematically. The major current need is for well-characterized, short-lived mammalian species. Inbred and random-bred mice and rats appear most appropriate.

The Institute has let a contract to the Charles River Laboratories to produce young and old inbred rats (Fisher 344) free of pathogenic organisms. These animals will be characterized pathologically, microbiologically, and nutritionally and will in several years be available for sale and distribution to interested investigators.

There is a need for other vertebrates for research on aging, and the Institute has given preliminary consideration to the problems involved. Among these is the relatively long lifespans of most vertebrates and the costliness of raising them to maturity and old age. Planning in this area continues.

Thought has been given to the selection of suitable invertebrates for aging studies. A major advantage of some invertebrates for research on aging is their short lifespan. Two conferences dealing with the use of invertebrates in aging research were held.

Aging and society

Changes in birth and death rates have greatly altered the age structure of the populations of the highly developed nations. Never before have countries had such high proportions of older persons. This change in population age structure has profound effects on the individuals in society and on society as a whole. Some of these effects are obvious. The totality of the implications of the changing age structure has not been thought through.

We have noted that 10 percent of the population of this country is over 65. If the number of persons in the country is held constant by birth control, if the age-specific death rates remain unchanged, and if migration is negligible, then the population will come to have about 15 percent of its members over 65, 10 percent over 70, and 3 percent over 80 years of age.

The aging individual in modern society is adjusting to his change in roles at a time when there are many older persons and when old age commands no particular status. He has financial problems, health problems, and the problem of what to do with himself.

The present age structure of the population poses problems for society. The percentage of the population in its productive prime is reduced by the increase

in persons over 65. These older persons have many needs— economic support, medical care, housing—all of which are expensive and should be met.

To encourage investigation of the psychological and sociological problems of aging, NICHD has placed a number of its training grants in the psychological and social sciences. In 1970, the Institute continued a contract to permit small meetings and interchanges designed to stimulate interest in research in this area. It also supported a training grant to the Gerontological Society to provide interim training to social scientists who plan to carry out research on aging.

Training

NICHD supported 211 students by 27 training grants in fiscal year 1970. Of these 68 percent were in the psychological and social sciences, 32 percent in the biological sciences. Eighty-two percent of the trainees were candidates for the doctorate and 18 percent were post-doctoral students. In addition, there were seven fellowships and seven research career development awardees.

NICHD conferences on aging, fiscal year 1970

Planning of research in studies of the biology of cellular aging.
Laboratory rodent as model system for research in the biology of aging.
Workshop No. 1 on invertebrate model systems.
Workshop No. 2 on invertebrate model systems.
Federally supported longitudinal aging research projects.

THE GERONTOLOGY RESEARCH CENTER (BALTIMORE)

The intramural program on aging of the NICHD is conducted at the Gerontology Research Center located on the grounds of the Baltimore City hospitals in Baltimore. The center is located in a $7.5 million research building which has been occupied since June 1968. The research program is organized under four branches, viz, laboratory of molecular aging, laboratory of cellular and comparative physiology, the clinical physiology branch, and the laboratory of behavioral sciences. Expansions in program originally planned for the new building have not been initiated because of Government-wide restrictions in hiring personnel. These programs include studies on aging in normal women, the genetic basis of aging with special reference to the mechanisms of DNA damage and repair, the physical-chemical organization of biomembranes, the role of immunity and immunological phenomena in senescence, age differences in response to drugs, and the relationship between life stresses, such as retirement, death of spouse, etc., to aging and disease.

During July 1968 the total staff of the Gerontology Research Center was 132. As of December 31, 1970, the staff was 116.

In addition to the intramural research program, the Gerontology Research Center sponsors a guest and visiting scientist program. Under the program the GRC provides laboratory space and other research resources, such as senescent animals, to investigators from universities and other research institutions to conduct research related to aging. Projects are reviewed for scientific merit and relevance to gerontology by an advisory committee composed of nongovernment scientists.

Any scientist may submit an application for use of the research resources of the GRC. The goal of this program is to increase the scope of research on aging by providing resources which the scientist may not have within its own institution.

At the present time, six foreign scientists are working with members of the staff of the GRC. In addition, laboratory facilities are being provided for 21 scentists from the Baltimore City hospitals and Johns Hopkins School of Medicine. Five scientists from other universities have utilized animals and laboratory facilities of the center.

As of December 1970, approximately 75 percent of the space in the gerontology research building is occupied. Complete occupancy depends on the availability of funds and authorized positions. NICHD-sponsored graduate training programs in gerontology are now turning out graduates so that young scientists are available.

Laboratory of molecular aging

It is widely believed that aging results in part from increasingly widespread misreading of the genetic message as a function of age. All information, required for the formation of proteins and enzymes necessary for maintenance of the life

of a cell, is coded within the genetically transmitted molecules of DNA. These messages must be continuously read throughout the life of each cell of the body. One way in which a message can be misread is through the misincorporation of ribonucleotides into DNA and deoxynucleotides into RNA, processes that are induced by metal ions. Chemical studies have demonstrated that such metal ions are indeed capable of differentiating between ribonucleotides and deoxynucleotides under some conditions but not others. Slight changes in concentration of the metal ion, or the acidity of the environment may interfere with placement of the proper nucleotide within a protein structure and thus interfere with its normal cellular function. These studies thus provide a mechanism by which subtle changes in a cell accompanying aging can have a marked influence on the accuracy of reading a genetic message.

For the first time, a technique has been developed for the isolation and biochemical characterization of the brush border of renal tubules. This technical advance will enable studies of the enzyme mechanisms of renal resorption at the membrane site of translocation and of the underlying causes of diseases in renal function with aging.

Correlated biochemical and ultrastructural alterations have been discovered in mitochondria from muscle of old animals. These deteriorative processes may provide a partial explanation for the decline in muscular performance with aging.

In studies of healing of wounds in relation to age, it has been found that old animals synthesize less fibrous scar tissue in the process of repairing a skin incision than do young animals. The scar tissues from the two age groups also differ in response to applied mechanical stress.

Laboratory of cellular and comparative physiology

Successful methods for culturing large numbers of rotifers have been developed. More important, marked age-associated changes which occur were determined. Threefold increases in the total dry weight, protein and acid phosphatase content of rotifers were observed following cessation of egg production. An increase in acid phosphatase activity was also demonstrated by histochemical techniques and found to be associated with a marked increase in inclusion bodies which have the enzymatic characteristics of lysosomes. These changes in enzymatic activities, as well as the increase in total protein content, suggest that quantitative alterations in gene activity occur during senescence.

Many of the current theories of biological aging are based on changes with age in the expression of genetic activity. It may be assumed that such changes would be manifested in either structural changes or in the rate of formation of RNA and/or proteins. Recent studies carried out in this laboratory have indicated that in the rat kidney the major portion of soluble RNA shows approximately a twofold decrease in turnover rate with age. For example, the half-lives were found to be 9.5 days for the old and 5.0 days for the young rat. The soluble RNA of spleen also showed significant reduction in turnover with age. However, no age-associated differences could be observed in liver.

The most obvious age changes in myocardial cells of 33-month-old rats as compared to 8-month-old animals was the presence of residual bodies which have been interpreted as age pigment by a number of investigators.

Residual bodies are evident in and confined only to the mitochondrial rows which separate the myofilaments in the cells of the myocardium. Autophagic vacuoles that contain partially degraded but recognizable cellular organelles, such as the mitochondria and glycogen particles, were observed in old rats. Lipid was found to be increased in the old myocardial cells and was visually different from that observed in young animals. This may suggest that there is a change in the chemical composition of the lipids with age. Thus age-related decrements in physiological capacity of heart tissue seem to result from decreases in the ability of the cells to produce energy due to the lysis of mitochondria as well as substrates such as lipids and glycogen.

Clinical physiology branch

A serious, new, sometimes life-threatening complication of the drug therapy of elderly diabetics has been discovered. The drug chlorpropamide was shown to produce a syndrome of "inappropriate antidiuretic hormone activity" in 4 percent of a diabetic clinic population. Since several hundred thousand diabetics in the United States receive this drug, it is estimated that thousands of elderly persons may have been suffering ill effects on a chronic basis.

Metabolic changes accompanying aging in man mimic those caused by diabetes. The differentiation of these processes has been aided by the development of a new technique for the analysis of the effectiveness of the hormone insulin. In normal aging there is no change in the sensitivity of body tissues to insulin, whereas diabetics show a decreased sensitivity to insulin. This differentiation of aging and diabetes is a further advance in the understanding of mechanisms of age changes in man, in that the previously described defect in insulin released from the pancreas appears to be the primary age change. Followup studies on the subjects of the Baltimore longitudinal study will have important clinical implications for the detection and treatment of diabetes in middle-aged people.

The effect of different levels of physical activity on certain physiological systems has been studied in the ongoing prospective study of human aging, the Baltimore longitudinal study. These male volunteers, ranging from approximately 20 to 100 years of age, estimated their daily activities (hours per day) for a period of 1 year. A twofold difference in activity level was found between the high-activity and low-activity groups. There were, however, almost no measurable differences in physiological characteristics between these two groups. If physical activity is to influence physiological performance in man, it would appear that very high levels of activity will be required, higher than that which occurs spontaneously in a normal community-dwelling population.

A new method for measurement of an enzyme called renin, which plays an important role in certain forms of hypertension, has been developed. The new technique will allow better diagnostic procedures to be established and in this way should further both the understanding of this major disease complex and its effective treatment. The technique is also a new contribution to the analytical chemistry of the small polypeptide hormones and should further research progress in this area.

Studies in the area of thyroid physiology have led to the discovery of a new class of intracellular thyroid hormone binding proteins. These may be involved in the action of the thyroid hormone, thyroxine. An experimental animal, the rat, has been shown for the first time to be unexpectedly similar in some ways to man and may prove to be a useful animal model for certain human disease states.

Laboratory of behavorial sciences

A major question in the area of learning and aging is whether methods can be devised to minimize declines in learning with age. Recent results clearly indicate that learning conditions can reduce performance decrements related to aging.

Results from subjects in the Baltimore longitudinal study are beginning to show age-related decrements in verbal learning. Learning occurs under one of two pace conditions. Some participants are given a very short time to respond during learning; others have a somewhat longer time to respond. Analyses of first performance data showed substantial age differences under both conditions, and the decrements with age were greater for those who learned at the fast pace.

For some participants, measures are now available for a second performance 6 to 7 years after the first. These longitudinal data show that performance has declined for all age groups at both pace conditions. For the men who had more time to respond, however, the decline was moderate and about the same for young and old; for the men who had little time to respond, however, the decline increased with age. The men over 60 who learned at the fast pace not only performed most poorly initially, but declined the most from first to second performance. By increasing the time to respond while learning, the decrement in learning of the older men was substantially reduced.

We now have evidence that verbal learning decrements in the aged are not absolute, but can be modified by appropriate selection of conditions under which learning takes place. The next research step is to identify all the important conditions which improve learning for the older person.

A group of eight patients with abnormal heart rhythms (premature ventricular contractions) were trained to control their hearts. All of the patients learned some degree of heart rate control. Five of these patients also showed a decrease in the prevalence of their premature beats. Four of these patients have continued to have few premature beats after the study. One patient has been followed more than 2 years.

These findings suggest that some aspects of cardiac function can be brought under voluntary control, and that once this control has been acquired it can

mediate clinically significant changes in cardiac function. Additional studies during the past year have shown that monkeys can also be taught to control their heart rates. This finding is important because it provides a highly reliable means for the study of the role of experience on heart function.

Young genetically identical groups of mice with long lifespans were more active than a young short-lived genetically identical group. They also maintained consistent high levels of activity throughout the mid-portion of their lifespan (14 to 23 months). At senescence, all groups were similar in activity level. Thus, genetic factors were related not only to activity level and longevity, but also to the rate of decrement in activity during the lifespan.

SCIENTIFIC INFORMATION CENTERS BRANCH

During the past year the branch published the fifth and sixth experimental issues of its journal Adult Development and Aging Abstracts. Publication of this journal was terminated with the sixth experimental issue.

The branch is continuing to act in a consulting capacity to the information centers of the International Center of Social Gerontology, Bagnolet, France.

BUDGETARY INFORMATION ON NICHD AGING RESEARCH, FISCAL YEAR 1970

	Number	Funds
Adult development and aging branch:		
Research grants	62	$3,225,564
Training grants	27	2,054,033
Fellowships	5	68,404
Research career development awards	7	182,570
Contracts	2	45,064
Subtotal	103	5,575,635
Adult Development and Aging Information Center		92,000
Gerontology Research Center		2,132,000
Total		7,799,635

ADDITIONAL INFORMATION

A more detailed description of individual extramural grants and contracts is given in the report, "Extramural Research on Aging, Description of Grants and Contracts, NICHD," which can be obtained by writing the Institute. A more detailed analysis of the training program including titles of these can be found in "Analysis of Research Training Grants in Aging, NICHD." This may be requested from the Institute.

The Gerontology Research Center's activities are described in a booklet, "The Gerontology Research Center, NICHD" available from the Institute.

ITEM 10: OFFICE OF ECONOMIC OPPORTUNITY

OFFICE OF ECONOMIC OPPORTUNITY,
EXECUTIVE OFFICE OF THE PRESIDENT,
Washington, D.C., January 15, 1971.

DEAR MR. CHAIRMAN: As requested in your November 25 letter, we are pleased to submit to the Senate Special Committee on Aging the fourth annual calendar year report on older persons programing at the Office of Economic Opportunity.

The enclosed material describes the variety of programs which are funded, delegated or directed out of OEO Headquarters and the agency's 10 regional offices. We have been pleased with the number of older persons programs which local community action agencies have been funding with local initiative moneys. We estimate that in fiscal year 1970 $3.14 million in local moneys was spent for senior opportunities and service-type programs in addition to the $6.8 million in SOS grants directly from OEO. We have just undertaken a national survey to obtain more information about SOS activities and shall be pleased to submit that report to the committee when it is completed later this year.

This agency's information retrieval systems are by no means precise for determining the number of aged served in general programs, a situation OEO's leadership is addressing itself to vigorously. In the meantime, using extrapola-

tions based on the universe of elderly poor and our own noncategorical outlays, we estimate that OEO in fiscal year 1970 spent approximately $69.7 million on the aged poor and served an aged poor population of about 1.5 to 1.75 million persons.

Under the agency reorganization, stewardship of policy questions affecting OEO's efforts to aid the aged poor resides in the Office of Special Programs. A Presidential appointee, Albert E. Abrahams, serves as Assistant Director of the new senior staff-level office. The Office of Special Programs concentrates not only on insuring that OEO programs meet their congressional mandate by including aid for the aged poor wherever feasible, but in forcing up for consideration within the Government as a whole substantive and long-range issues affecting this target population. In that regard, the Assistant Director for Special Programs serves on various intragovernmental panels. The office also maintains liaison on OEO's behalf with the various Federal departments and agencies serving the aged poor as well as with the major national senior organizations.

Through the coordinating function of the Office of Special Programs, there has been increased focus on assuring that the needs of the elderly are met through such all-age programs as VISTA, neighborhood health centers, neighborhood legal services, and those for Indians. Special Programs has taken the lead in bringing together the various OEO offices that play a part in developing improved programing for such needs as nutrition for the elderly.

We also are pleased to report that OEO's Older Persons Advisory Committee was reactivated last year, under the cochairmanship of Tony Kubek and Robert Blue, and already is producing benefits in the form of sound and thoughtful advice and recommendations.

On behalf of the Office of Economic Opportunity, may I express our appreciation for your continuing interest in and support for our activities on behalf of and in cooperation with the elderly poor.

Sincerely,

FRANK C. CARLUCCI,
Acting Director.

[Enclosure]

THE OFFICE OF ECONOMIC OPPORTUNITY 1970 ANNUAL REPORT FOR OLDER PERSONS ACTIVITIES AND PROGRAMS

Efforts of the Office of Economic Opportunity for the elderly will increasingly be affected by the fact that the poor are increasingly the elderly. One of every 10 Americans has reached age 65 and one of every four at that age and above is poor. The elderly and particularly the very old are increasing more rapidly in numbers than any other age group in the population and progressively are becoming a larger proportion of the total universe of poverty in this country. Those 65 years and above accounted for 15 percent of all poor persons in 1959, 18 percent in 1968, while in 1970 the 4.8 million elderly poor represent 20 percent of the total poor population. When those between 55 and 64 years are included an additional two million poor must be added and the proportion of the total poor rises to 28 percent. In many communities and in some whole States, the percentages of the elderly and the elderly poor are much higher than the national figures.

We have reason to believe that one factor for these proportions is that the poverty cycle for many younger Americans is being broken. Some of the programs made possible by such legislation as the Economic Opportunity Act are paying off.

But the increase in the proportionate number of the elderly poor does not alone reflect a decrease in the number of younger poor. It does reflect, in large part, a dramatic increase in the average life span of people once they reach age 65. While once people were expected to live just a few years in retirement, the man who today achieves age 65 can be expected to live an average 14 years longer and women are averaging an additional 16 years past age 65.

The aged poor represent all aspects of the poverty syndrome—unemployment, poor health, undereducation, poor housing—with some important differences in characteristics resulting from the multiple handicaps of age itself which make inapplicable many of the traditional solutions to poverty problems. Principal among these is the reality that relatively few of these persons are, will, or could long remain in the regular job market.

Retirement planning has not taken into account these increased years of life and people who have lived comfortable middle-class lives are finding themselves in poverty after their retirement funds run short. Thus, while OEO continues its

concern for the elderly who have always been poor, including many minority group members, we are also compelled to direct our attention to these new poor and generally to the various needs of the heterogeneous aging poor.

An adequate income is the first line of defense against poverty among older Americans. OEO's special contribution in this regard among the Federal agencies are those new and innovative programs which will provide employment income for the elderly poor in their lengthening years of post-55 and post-65 life. Foster grandparents, the senior aides of Mainstream, as well as that program's green thumb and green light components, are proven models. Most of these are based on performing necessary public service tasks, but they have also served as training programs for eventual employment in the private sector. Most recently OEO completed a study on the use of older persons in day care for children. This anticipates the quantum increase in the demand for this service expected to take place in the 1970's. OEO has under consideration several other research and demonstration projects geared to the provision of new types of employment roles for older Americans who need and desire to work.

Increased income is not the only benefit of such employment. An increased sense of worth appears directly linked with better health, and in many cases a lessening of the use of such tax-supported facilities as nursing homes.

Income is not, of course, the only need of the elderly. Modest amounts of additional income do not necessarily provide adequate health care, transportation or housing. Therefore, any comprehensive aid for the elderly poor must have a balanced income and service strategy. In turn, the service strategy should wherever possible meet, through actual provision or referral, the array of needs that are equally vital to the elderly such as housing, nutrition, transportation, socialization and health care.

In regard to services, OEO sees its special contribution as the search for additional ways of assuring that these services, whether funded by OEO or other government or voluntary agencies, are available and reach the older poor in the comprehensive manner required. Senior opportunities and services (SOS) programs are proving most successful as models for this approach. Many of them include the Project FIND outreach and referral components which have proven of significant value in informing older people about benefits to which they are already entitled.

OEO estimates that it presently serves 1,500,000 to 1,750,000 of the elderly poor including the 700,000 reached by SOS programs—$69.7 million is the approximate cost of serving this group of the poverty population.

RELATIONS WITH THE VOLUNTARY SECTOR AND OTHER GOVERNMENT AGENCIES

OEO is represented on all cabinet and subcabinet interdepartmental committees and task forces on the elderly. Among questions being raised by the Office of Special Programs for consideration in this agency and throughout government are these: Do government and private retirement benefits provide financial security to a population that can increasingly expect to live many years past the age of 65? Are there ways to link older persons who possess the skills and want to keep active with unmet service needs of our society? What should be the proper balance between providing the older poor with income and with needed social services? These questions go to the heart of our society's attitudes and policies toward older citizens, poor and otherwise.

The Office of Economic Opportunity has been involved in the preliminary activities of the White House Conference on Aging scheduled for November 1971. OEO is represented on several of the 14 task force secretariats, which are treating such topics as income, health, housing, nutrition, employment-retirement, and transportation.

On both the policy planning and programatic levels, there is a continuing exchange between OEO, AOA and other agencies of HEW. We carry out joint funding wherever feasible and possible. Data is exchanged to avoid duplication as well as to enhance the program of each agency. We hope to better correlate OEO research and demonstration programs on the elderly with those of HEW.

OEO has maintained on an ad hoc basis a close working relationship with the model cities agency of the Department of Housing and Urban Development. The primary joint effort of the two agencies is to bring about a closer working relationship between community action agencies and model cities programs in serving the elderly in model cities areas. This has made possible the joint funding of neighborhood facilities centers, employment of the elderly poor, out-reach programs within the model city area, and information and referral programs.

Mr. Abrahams and OEO older persons staff participate in a number of conferences and seminars of national social welfare, voluntary, and religious organizations.

Mr. Abrahams recently established a consultation committee as an informal means of complementing the work of the Older Persons Advisory Committee. The consultation committee is comprised of representatives from the major national senior organizations, namely the American Association of Retired Persons-National Retired Teachers Association, the National Association for Retired Civil Employees, the Gerontological Society, the National Council on Aging, National Council of Senior Citizens, and the National Farmers Union-Green Thumb. The committee members advise OEO in the problems of the older poor as their constituents see them and suggest new measures the agency can undertake. OEO, in turn, urges the associations to look within their own structures and resources to see if the utmost is being done to solve the problems of the older poor at the national, State, and local levels.

OLDER PERSONS ADVISORY COMMITTEE

The Office of Economic Opportunity in 1970 reestablished an Older Persons Advisory Committee to help assure that all OEO programs, whenever feasible, address themselves to the needs of the elderly poor. The committee was appointed to advise the agency director of the nature and extent of specific problems faced by the elderly poor, the impact of OEO and other antipoverty efforts on the plight of older persons at the local level, and the consolidation, simplification, and strengthening of local, State and national programs affecting the elderly. In addition, it is intended that the committee will encourage the establishment of local programs involving private groups and State and local governments to assist the older poor.

The Older Persons Advisory Committee has 20 members, most of whom are elderly lay citizens representing a wide ethnic, geographic, and occupational mix. Many of the members are participants in OEO-sponsored programs. Professionals in the field of aging are also among the members, not as representatives of their particular agencies and organizations, but as individual workers in the fie d. The Office of Special Programs provides the committee with staff assistance.

The Advisory Committee is headed by Tony Kubek, a former New York Yankees baseball player and presently a national telecaster, Cochairman of the committee is Robert Blue, former Governor of Iowa. Other committee members include:

Albert Abrams, Albany, N.Y.; Cruz Alvarez, Mesilla, N. Mex.; Chester Blubaugh, Lebanon, Ind.; Mrs. Mary Louise Johns, San Antonio, Tex.; Dr. Donald Kent, University Park, Penn.; Dr. Juanita Kreps, Durham, N.C.; Mrs. Angela Little Beaver, Winnebago, Nebr.; Mother Bernadette de Lourdes, Trumbull, Conn.; Mrs. Robert Morris, Denver, Colo.; Paul Caldwell, Pittsburgh, Pa.; Orin Crump, Sandy, Utah; John Hickey, Buffalo, N.Y.; Mrs. Ida May Petty, Baltimore, Md.; John Pioda, Atlanta, Ga.; Mrs. Mary Powell, Akron, Ohio; Miss Ollie Randall, New York, N.Y.; Rev. Richard Waggy, Brighton, Colo.; Mrs. Minnie Wooden, Washington, D.C.

Like many advisory committee members, Mr. Kubek was forced to retire from his first career—as a baseball player. Unlike many of the other committee members he is in his early thirties and has a second career. Mr. Kubek's nationally known name, and his personal experience with the problems of retirement, provide added public attention to the problems of the older poor as he functions in his committee role. This includes field trips around the country to OEO and other programs for older persons. Other members of the committee are visiting their local community action agencies to observe their activities for the older poor. Members are also meeting with OEO State and regional officials.

At its first meeting held in September 1970, the advisory body urged the OEO director to use his influence to eliminate the earnings test for social security recipients and to work for the changing of national priorities so that the needs of older persons could be given more attention.

In the future the committee plans to continue its review of OEO and other Federal programs. It has indicated an interest in insuring the participation of the older poor, and a focus on their needs, in all phases of the 1971 White House Conference on Aging.

REGIONAL AGING COORDINATORS

During 1970, a coordinator on aging was appointed in each of the 10 OEO regional offices to provide assistance to the regional directors, the State economic opportunity offices, and the community action agencies in insuring more involvement of the elderly poor in all programs of OEO, and the better use of services provided by State and other community agencies.

The regional aging coordinators usually have additional assignments in the fields of health, nutrition, or emergency food and medical services. These related functions enable the coordinators to make appropriate SOS funding recommendations and to bring together the various concerns, needs and services relating to the elderly poor.

To maximize the functions and role of the coordinators on aging, an orientation and training conference was conducted during the last quarter of 1970. The regional offices coordinators on aging were joined by the chiefs of their divisions, governmental and private sector relations, during the conference.

During the 2-day meeting the coordinators were briefed by the national headquarters staff on the function of the coordinator within the regional office structure, the OEO contract requirements with the National Council on the Aging, the OEO's role in the Mainstream program of the Department of Labor's manpower programs, the need for State economic opportunity offices, and CAA's involvement in planning for the White House Conference on the Aging, and the first OEO national survey of older persons programs begun, sponsored, funded, or spunoff by local community action agencies.

Additionally, OEO strategy and plans relating to the elderly were presented to and discussed by the participants, and the agency's and the administration's policies for all elderly and the poor in particular were outlined in some detail.

Regular training and review conferences are being planned by the national headquarters staff, in conjunction with the regional training and program specialists, to provide the coordinators a systematic review of SOS programs, an opportunity to be kept abreast of new and innovative programs begun by OEO's Office of Program Development, and the results and implications of new census, demographic, geographic, and social data upon program needs and designs for the elderly poor.

MANPOWER PROGRAMS

(EOA—Title I)

OEO funds three manpower programs that serve the elderly—the concentrated employment program (CEP), new careers, and Operation Mainstream. The administration and operation of all three have been delegated to the Department of Labor. Operation Mainstream has by far the most significant impact on the elderly of any of OEO's manpower programs for that age group.

The most recent guidelines published by the Department of Labor state Operation Mainstream's purpose to be the provision of work-training and employment projects, augmented by necessary supportive services designed to provide permanent jobs at decent wages for adults with a history of chronic unemployment. Designed for rural areas and towns, projects concentrate on work experience and training activities that will improve communities and those low-income areas where the projects may take place. Such projects may seek to decrease air and water pollution, improve parks, protect wildlife, rehabilitate slum housing, or extend education, health, and social services.

Priority enrollment is given to those who have been chronically unemployed (defined as unemployed for more than 15 consecutive weeks, repeatedly unemployed during the past 2 years, or employed less than 20 hours a week for more than 26 consecutive weeks); have completed some training but remain unemployed; lack current prospects for training or employment because of age or some other factor. In fiscal 1970, the obligation for Mainstream was $51 million, compared with $41 million in fiscal 1969, and enrollment as of June 1970 totaled 12,687 compared with 10,261 in June 1969.

Operation Mainstream includes several projects that concentrate exclusively on people over 55 who meet the previously stated qualifications. In June 1970, enrollment opportunities in these older worker projects totaled 4,628 compared with 4,373 slots in June 1969. Actual enrollment in these older worker projects totaled 4,315 in June 1970. Outside of the older persons project, an additional 900 enrollment slots were provided for workers 45 and over in the regular Mainstream program.

The largest of the older worker programs is the Green Thumb program, sponsored by the National Farmers Union (under national contract) and now operating in 15 States. Subsidiary to the Green Thumb is the Green Light program, directed at serving unemployed older women and operating in 10 States. These two programs were funded at $5.4 million in fiscal year 1970 compared with $5.2 million in fiscal year 1969, with enrollment opportunities of 2,435 in fiscal year 1970, and 2,313 in fiscal year 1969. At the end of June 1970, there were 2047 enrollees in the Green Thumb program and 202 enrollees in the Green Light program.

There were four other older persons programs funded during 1970. A contract with the National Council of Senior Citizens was expanded from 1,132 authorized slots in 1969, to 1,148 slots in 1970. Similarly, a contract with the National Retired Teachers' Association was expanded from 313 slots to 433 slots. Contracts with Virginia State College, 115 slots, and the National Council on Aging, 500 slots, were renewed at the same level. These programs involve enrollees in a variety of social, health, and educational services to their communities.

SENIOR OPPORTUNITIES AND SERVICES

(EOA—Title II, Section 222(a)7)

The Senior Opportunities and Services program authorized by the 1967 amendments to the Economic Opportunity Act, is designed to identify and meet the special economic, health, employment, welfare, and other needs of persons above the age of 60 in projects which serve and/or employ older persons as the exclusive or predominant participant or employee group. The projects deal with specific problems of the older poor that cannot practically be met by more general programs designed to serve all or younger age groups.

Such projects develop and provide new employment, volunteer services, and referral; stimulate and create additional services and programs to remedy gaps and deficiencies in existing programs; and attempt to modify existing eligibility requirements and program structures to facilitate the greater use of, and participation in, public services by the older poor.

These projects provide maximum opportunity for older poor persons to develop, direct, and/or administer such programs while utilizing existing services and other programs to the maximum extent feasible.

In fiscal year 1970, a total of $6.8 million was allocated from senior opportunities and services funds, of which $400,000 was used for migrant and Indian projects and a special project conducted by VISTA. The total of SOS programs increased from 194 to 208 and served more than 700,000 elderly poor.

Most SOS programs serve relatively large numbers of persons at a low unit cost, estimated in fiscal year 1970 to be approximately $10. Such services as meals provided and participation in senior center activities are repetitive and may occur daily or weekly. Others may be one-time or occasional services.

Contributing to the low unit cost in Federal dollars is the significant ratio of local support of SOS programs, which consists of volunteer work, locally provided space, donated supplies and equipment as well as substantial amounts of cash from United Funds, city and county government entities, and other local sources. In fiscal year 1970, the non-Federal share amounted to 38 percent for programs as a whole, while for many individual projects the non-Federal share amounted to as much as 75 to 90 percent of total costs.

SOS program elements

While OEO's SOS programs are of recent origin, they are generally based upon experience gained in a series of singularly successful pilot projects conducted by CAP's R. & D. division and dating back to the earliest days of OEO. These basic parent programs include foster grandparents programs, medicare alert, Project FIND, and Project REASON. Under contract with OEO, the National Council on the Aging has provided and continues to provide major professional assistance in the conception and testing of aging programs.

Most of these programs have a double impact; the elderly help the elderly. In the well-known foster grandparent program, the gains made by handicapped children are matched by the gains in health, self-sufficiency, and general well-being of the elderly. It has been well documented that general-purpose, multi-generational programs do not adequately serve the needs of the older poor and

that social programs aimed at the specific problems of older persons are more effective.

Following are descriptive outlines illustrating the scope of senior opportunities and services programs:

Employment

A major and lasting benefit of many SOS programs is their extensive training and use of elderly poor persons to assist others and the extent to which other local, State, and Federal as well as private agencies are recognizing the usefulness of this service and adding elderly poor nonprofessional and paraprofessional aides to their own staffs. The institutional change already effected in health, educational, and welfare institutions is significant. Many SOS programs start with a commitment from other public agencies to give full- or part-time employment to seniors once they have received training.

Economic development

A small, short-term senior opportunities and services grant to a rural community action agency in northeastern Washington State last June is having such a dramatic effect upon the economic development of the community that it is attracting national attention and has been the subject of a hearing by the Senate Special Committee on Aging. In the small, one-industry town of Chelewah, the local brick factory, the only significant industrial employer, gave notice to its 125 employees that it was closing the plant and moving out. Since most of the employees were over 55, had been with the company for many years and had no alternative sources of employment in sight, the local CAA director appealed to OEO's regional aging specialist for help. At his request, OEO's technical assistance contractor in aging, the National Council on the Aging, dispatched two national experts on industrial displacement to the community. They met with all elements of the community and recommended a course of action. OEO made a small SOS grant to the CAA to staff and carry out the community mobilization effort recommended by the experts. A series of communitywide meetings and workshops succeeded in gaining such intense interest and support that not only were jobs quickly found for the displaced older workers but an unprecedented surge in economic development also was set in motion.

Attached by the community's response to the crisis, a new garment industry moved to the town, creating many new jobs. An industrial park is being developed with prospects of attracting other new and diversified employers. All indices of economic well-being are rising. The town is on the move.

The State's Governor was so impressed by the community action techniques by which Chelewah organized itself for self-help that he instructed the State labor department to adopt them as standard procedure for economic planning in other communities of Washington.

While economic development projects have limited possibilities among the older poor, a considerable number of handcraft production and marketing cooperatives and corporations are emerging to employ the skills of the elderly poor and contribute to their incomes.

Housing

Housing services for the older poor are a feature of most SOS programs. Many have links with local housing authorities, helping them to locate units for HUD's leased housing program and screening and referring applicants for these subsidized housing units.

Health

A small health planning program for the elderly poor in Alaska is spearheading and providing leadership for that State's entire comprehensive health planning process preparatory to the State qualifying for U.S. Public Health Service grants.

Other programs are providing home health services for the elderly which eventually will be supported by medicare and medicaid payments. At the same time, these programs reduce the costs of medicare by keeping them at home where most prefer to remain.

A popular type of program trains elderly persons to serve as home health aides to the older poor.

Nutrition

Poor nutrition is recognized as a major physical and mental health problem of the elderly. Many SOS programs serve as agents of the food stamp plan to reach out and facilitate the utilization of the program by the elderly poor.

Others in concentrated locations provide a daily hot meal, using surplus commodities and school lunch facilities at off hours. Some programs operate "Meals on Wheels" components to take food to disabled or shut-in elderly poor. All of these programs provide employment to older persons as cooks, servers, dieticians, et cetera.

Transportation

Many SOS programs are attacking the difficult transportation problem of the elderly poor. A project in rural Pierce County, Wash., is using a mobile unit to deliver services on a scheduled basis to the dispersed, elder population. Many projects use surplus government vehicles and volunteer drivers to provide emergency transportation. In an Oregon CAA, the Administration on Aging is providing funds for the transportation component of an SOS program.

Many SOS programs provide consumer education for the elderly poor, training them in areas of food buying and preparation, budgeting, and home management.

Discount clubs and co-ops enable the elderly to reduce the costs of nonprescription drugs, pharmaceuticals and other commodities. In some instances food cooperatives of the elderly purchase commodities in bulk and deliver grocery products to seniors in their homes at considerable savings.

Unwary older persons are trained to recognize and avoid the fraudulent insurance and other racketeers who often prey on old people.

Outreach and referral services

An almost universal service of OEO's aging programs is the use of trained low-income aides to inform and assist the elderly poor to better utilize the other programs and services for which they are eligible. An early nationwide OEO program—medicare alert—and subsequently project FIND, disclosed that large numbers of the elderly poor because of ignorance, language barriers, shyness, or other reasons were failing to register for medicare, food programs, and other services for which they are eligible. A major service to this poorest and most helpless segment of the older poor is that of finding and connecting them with existing services. It is well established that older poor persons, trained as aides and possessing language qualifications, are able to reach this group more effectively than anyone else, including professional social workers.

Evaluation of SOS programs

In 1970 an independent evaluation of a representative sampling of SOS projects was completed by Kirschner Associates and resulted in the following significant findings:

(1) They have been found to be low in cost, relative to many other kinds of programs, both in terms of total programs and unit cost per beneficiary.

(2) The elderly participate more actively and respond more effectively to special programs designed for their own needs than to general purpose, multigenerational programs. Older persons are shy and unable to compete with more vocal, assertive and militant youth and younger adults in mixed groups.

(3) They have demonstrated that programs which recognize the skills and worth of the elderly, allow them to participate in community affairs and give them an opportunity for service result in marked improvements in their sense of dignity and self-importance, their physical and emotional health, and general well-being.

(4) They have been found in many instances to have a double impact upon poverty; the elderly poor improve their own financial and emotional status by serving others. The foster grandparent program is a good example with measurable antipoverty benefits accruing both tho the older people and the disadvantaged children they serve.

(5) The programs have unique appeal to local governments, church, and other groups and attract a more generous measure of local resource support than many other types of programs. Joint funding by other agencies and major local support in terms of funds, space, and voluntary service are common.

(6) They have demonstrated considerable success in the fundamental mission of affecting change in other institutions; i.e., the use of elderly nonprofessional aides is becoming widespread among many health, social welfare, and educational institutions, creating a new career field of important dimensions for the older poor.

(7) They have the flexibility to attack any of the major local problems of the elderly poor and the poor generally, whether they be those of employment, health, housing transportation, nutrition, or something else.

(8) Finally and significantly, these programs have been found to provide a unique and urgently needed outreach and referral service for the Nation's major national social welfare programs. OEO frequently lifts individuals and old couples out of poverty at minimal program cost to the agency. At the same time the other programs are assisted in fulfilling their mission more effectively.

Fiscal year 1971 findings and plans

In fiscal year 1971, a minimum $7.8 million will be used to continue the funding of local senior opportunities and services projects and, for the first time, assume the costs of training and technical assistance services in the older persons program area.

A continued strong training and technical assistance effort, conducted by the National Council on the Aging, is considered essential to focus local projects on their prime goals of resource mobilization and institutional change. With the assumption of the cost of this contract, the fiscal year 1971 budget will provide for a small increase in funds for operating field programs.

SERVING THE OLDER POOR THROUGH ALL-AGE PROGRAMS

The newly created Office of Special Programs coordinating function has increased the agency's emphasis on meeting the needs of the elderly in and through such all-age programs as neighborhood health centers, legal services, community action agencies, programs for Indians and migrants, and VISTA. Special Programs maintains liaison with all operational segments of the agency, serving within OEO as an advocate for the elderly poor.

Health affairs programs

The Office of Health Affairs makes funds available, especially through the comprehensive health services program and emergency food and medical services program, to provide assistance to the elderly poor. About $7.4 million is spent to serve the elderly in 50 comprehensive health services demonstration projects being developed across the country. Approximately $16.2 million is channeled through the emergency food and medical services programs to meet the nutrition needs of the elderly poor in projects aimed specifically at the aged and those designed for all age groups including the elderly. Special pilot projects have included meals-on-wheels and hot lunch programs. The Office of Special Programs is pulling together the experience of EFM, as well as SOS programs to develop improved and better coordinated programing in the area of nutrition for the elderly. The problem here is not just to provide nutritious meals for the older poor, but to build that feature into a comprehensive service and income program accompanied with adequate research and evaluation to assure effectiveness and replicability.

Older persons comprise 250,000 of the more than 2,500,000 poor people who are alcoholics. The newly established alcoholism counseling and recovery program plans to reach as many as 50,000. Some of the services provided include medical, dental, and social services, and nutrition and consumer education.

Legal services programs

The 265 neighborhood legal services projects handle the legal problems of all who are within the OEO poverty guidelines. No breakdown by age groups is available, but clearly a number of the elderly are being served by the local projects at present and more will be in the future as their needs and problems are focused upon.

VISTA

Volunteers in Service to America (VISTA) has always sought older persons as volunteers and the percentage serving at a given time has fluctuated between 6 percent and 16 percent. A total of 2,700 older persons, or 12 percent of the overall VISTA enrollment since the program's inception, are or have been in the age 50 and over category. Nearly half of them have served in VISTA for more than 1 year. They represent every profession and skill and bring to impoverished communities a wealth of experience and workable knowledge.

VISTA is attempting to recruit more older volunteers. The emphasis on attracting the skilled volunteer is opening new channels for retired specialists to contribute their abilities. Moreover, all VISTA activities include reaching older persons in every community. VISTA helps them obtain services designed for them, and more important, involves them in community activities.

VISTA has made special efforts to recruit older poor persons as volunteers in the Southwest, on Indian reservations, in rural southeastern and northeastern regions and in the inner city. For example, Ozark opportunities in rural Arkansas, the Sioux in South Dakota, the Blackfeet in Montana, and the Search and Find project in Boston, have recruited and trained local residents to serve as community leaders. Four hundred volunteers age 50 or over were serving in 160 different projects at the end of 1970, while 132 had completed their service and terminated within the year.

RESEARCH AND DEMONSTRATION PROJECTS

OEO has planned its research and demonstration projects so that the knowledge and experience gained from them could be channeled not only to local community action agencies, but to many other public, private, and volunteer agencies which increasingly are concerning themselves with the problems of the older poor. Among such projects specifically designed to aid the aged poor are:

Project Late Start

The National Retired Teachers Association and the American Association of Retired Persons received in 1970 a second-year grant of $252,000 to continue a research project to test, in four diverse geographic and ethnic locations, the thesis that low-income elderly people can have their life pattern altered and their problems ameliorated by a concentrated group experience which seeks to be educational and informative. Through group discussions with their peers and professionals from social service agencies, participants reassess and reinforce their individual potentials. A new sense of self-worth and belonging to the mainstream of American life and an espirit de corps are created and provide a bulwark against the sometimes incapacitating experiences of daily living. Instructors provide enrollees with needed information on programs and services available to them, employment opportunities, consumer advice, citizenship rights and training, housing, health care, etc., to enhance the self-sufficiency, dignity, and purpose of their mature years. The 1970 grant provides for an assessment of the long-term effects upon the independence and well-being of participants and a test of the employment potential of enrollees.

The experimental project, which had 650 enrollees in 1970, is located in four cities: Augusta, Maine; Toledo, Ohio; Charlotte, N.C.; and Brownsville, Tex. There are four, 10-week cycles during which the four groups participate for 5 days a week in a series of specially designed discussion groups, lectures, demonstrations, social experiences, and guidance sessions. Hot meals and preventive medical and health care are provided, and have resulted in improved emotional and physical health of the participants. Letters from the community action agencies and other sources in communities where the program is operating report measurable influence of the program in effecting local institutional change.

Rural housing repair

A pilot program to repair the substandard homes of elderly poor persons in a four-county area of eastern Kentucky was refunded in fiscal year 1970. It is administered by the Eastern Kentucky Housing Development Corp., a delegate agency of the Community Action Council in Leslie, Knott, Letcher, and Perry Counties. The program trains older poor persons as construction workers to repair homes owned by elderly, blind, or disabled recipients of public assistance.

The project has a double focus: To solve the area's substandard housing problem and to reduce unemployment, especially among the elderly poor. This is a highly coordinated project with several other Federal and State agencies participating and contributing funds. The fiscal year 1969 funding level was $355,000 and the obligations for fiscal year 1970 were $489,000. Over the past 2 years, since the program was first funded, 840 homes have been repaired. The project involves about 1,000 participants, most of them 65 and older. The Office of Economic Opportunity's funds fully support the salaries of 69 men who would otherwise be unemployed because of old age and/or poor health.

Housing assistance and social service project

A research and demonstration project conducted by the Cambridge (Mass.) Economic Opportunity Committee has mobilized the elderly poor into an effective action group around a common issue affecting their lives: Critical housing problems and solutions to their need for related social services required for their well-being. The project was refunded in 1970 for a second year for $229,651.

Community development rural programs

Nine OEO rural projects seek to overcome the complex problems of bringing services to and economically developing sparsely populated areas. The programs are experimenting with self-supporting transportation systems, leadership training, saturation use of outreach centers, development of small business enterprises, and a communications system to increase awareness of opportunities and services available to the rural poor. Although these projects are not aimed exclusively at the older poor, they reach substantial numbers of such people because of the rural population's nature. Mass exodus from low-income rural areas in recent years has meant that those left behind (the very old and the very young) are often worse off than before. Among low-income families in these areas, one of every four heads of households is 65 years of age or older. It is estimated that approximately $0.2 million of the obligations for fiscal year 1970 was directed to the poor 55 years old and older.

Consumer programs

OEO's consumer research and demonstration programs reach the elderly poor, although this is not the only target group. An estimated $0.1 million was aimed at older poor citizens in fiscal year 1970.

Legal research and services for the elderly

Legal Research and Services for the Elderly (LRSE), a national demonstration project, was initiated in fiscal year 1968. Its latest funding, in the amount of $414,735, was announced in December 1970. The grantee is the Washington-based National Council of Senior Citizens.

LRSE was funded to research and identify the particular problems facing the elderly poor; to examine the law and the major legally sanctioned institutions that affect the elderly; to devise models and methodologies to meet their needs; to provide new sytsems for eliminating the negative impact to our social, economic, and administrative institutions on their lives; and to devise methods for educating the elderly poor community as to their rights.

There was a great deal of experimentation when the program was originally devised. The first year's operations covered urban and rural areas in different sections of the country, and involved both operational and research aspects. Under the original grant, the National Council funded law schools, legal services programs, community action agencies, an elderly organization and an economic development corporation. Through this preliminary experimentation and research, LRSE has determined that the most significant legal issues affecting the elderly reside in the areas of housing, health, income, and State legislation. They have further determined that these problems can be most effectively solved through a combination of legislative reform, litigation, administrative representation, and governmental largesse.

In 1970 LRSE prepared a working paper delineating its activities for the Special Committee on Aging of the U.S. Senate. Copies were sent to every OEO neighborhood legal services office, all community action agencies and to the more than 200 SOS projects.

The program as presently funded includes a number of projects to permit a cross-fertilization of ideas and methods for achieving results in each area. The development of lay advocates, trainers, ombudsmen, systems for community education, model legislation, and litigational techniques will produce a variety of strategies to be used in responding to the problems of the elderly. The following sub-grants are designed to provide the operational structures for developing and institutionalizing these new methods of impact:

Western Center on Law and Poverty (Housing Opportunities for the West Side Elderly).—This project has both researched and demonstrated that senior citizens' housing problems are divisible from those of other poor persons. Housing patterns specifically affecting the elderly do exist—retirement communities, neighborhoods and entire communities where the young have moved away to seek employment, marginal districts where land for development is at a premium and rent increases drastically, public housing constructed specifically for the elderly. The project has developed an expertise in housing problems affecting the aged. The patterns it has identified and the litigational and administrative techniques it is developing can serve as a national resource for OEO.

California Rural Legal Assistance (CRLA).—As with housing, the opportunities for legal action in the area of elderly health problems are abundant. In 1969, Americans spent more than $60 billion on health care and the Nation's 20 million elderly are the chief users of the Nation's health system. The

CRLA's project concentrates almost exclusively on the health care needs of the elderly, through litigation, administrative action, legislation, and community development on both a State and municipal level. This project has two main features: One offers effective training and employment of elderly citizens as legal paraprofessionals to work on behalf of the poor and aged in various agencies and institutions in the health-care field; the second is a legal research and litigation program focusing on significant issues in health-care law affecting the elderly. Again, the strategies and data developed from these programs will provide a back-up resource for the entire agency concerning the recurring patterns of health problems affecting the elderly and the most effective methods for solving these inadequacies.

The elderly component at the Columbia Center on Social Welfare Policy and Law.—This has been the basic research arm of the grant concerning income maintenance (welfare and medicare, medicaid) issues. Because the earning power of the elderly is insubstantial or nonexistent, and income largely consists of social security pensions and public assistance, legal review of benefit programs is vital. The center has been concentrating on identifying the major issues affecting the elderly (retirement benefits, old-age assistance, aid to the blind, disability benefits, conflicting State requirements, etc.). The goal is to establish an awareness of these issues through litigation, to develop materials to identify the issues (pleadings and legal memorandums), and to serve as a catalyst for initiating a variety of legal responses to these problems.

The Council of Elders in Boston.—This section of the project involves a grant to a senior citizen organization and includes funds to retain a law firm. The council establishes basic policy direction and the firm advises and assists its clients in achieving results. In the past year, this program has developed a State legislative program to benefit the elderly poor and was instrumental in designing the bill which created a cabinet-level Department of Elder Affairs. The program has also been working on a community advocate program and can share in the expertise developed at CRLA. The example this program has set by securing this type of legal retainer for a special interest group is a significant precedent to establish on behalf of the interests of the poverty community.

Miami Legal Services Senior Citizens Center.—Finally, the LRSE grant to the Miami legal services program is the most purely operational project in this grant complex. Yet it also serves as a unique example of what can be done in an elderly poor community whose members are susceptible to the housing, income, and health problems which are being explored by the other grantees. The project has provided substantial individual legal assistance as well as being involved in law reform, legislation and community organization, and education.

It is evident that this grant to the National Council is multifaceted and multifunctional. The program is experimental and research-oriented, but also has a limited operational capacity. It has already identified and isolated the recurring legal problems of the elderly poor and has begun to research the specific areas of concern. It has implemented tactics for creating institutional change through the use of legislation, litigation, and administrative representation. Now it is developing new systems and models through advocate training, development of community ombudsmen, use of a private law firm, consolidation of litigational techniques, and development of model legislation. The program's research efforts have nourished the operational components which, in turn, have begun to develop new models to be further replicated throughout the country.

A study of the use of older persons in child care

I. FINDINGS

Urban Systems Research and Engineering, Inc., of Cambridge, Mass., recently completed a study for OEO on "Meeting the Needs of the Elderly Poor: A Study of the Use of Older Persons in Child Care." Excerpts from their report follow:

"The picture of the life of the elderly in America provided by the study highlights not only the quantity of economic circumstances of many older persons, but also the extent and nature of their social isolation from the community around them.

"In reviewing the methods by which the Federal Government can alleviate the hardship of this group, it is clear that increases in the level of retirement benefits through social security or the institution of income maintenance programs are both extremely costly alternatives and neither attempts to meet the need for worthwhile participation in the Nation's economic life that many older persons express. For this reason it is sensible to look at the possibilities which exist for the Federal Government to intervene in the labor market on behalf of older persons. By making an older person a more attractive potential employee, either by training, information, or by a policy of employment subsidation, the Government can raise the level of an older person's income by an amount which considerably exceed the Federal contribution; at the same time, the individual is given an opportunity to renew his involvement with the world around him and to maintain his sense of dignity and self-respect.

"The principles and methods by which the Federal Government should intervene in the labor market to promote the employment of older persons, and thereby to redistribute income in their favor, is the subject matter of this report. The losses in economic efficiency which arise from intervention of this kind are more than offset by the measured gains in the Government's distributional objectives for the low-income elderly if the methods of intervention outlined in this report are adopted. Programs for the low-income elderly which provide additional jobs through intervention in the labor market can therefore become cost-effective elements of the overall Federal effort.

"In carrying out this analysis, we have conducted an in-depth study of the ways in which the Government can assist the elderly by intervening in a particular market—the market for child-care workers. This market appears for several reasons to be on the verge of a substantial expansion, and the area of child care is one for which older persons, are in many ways, well suited. In carrying out this analysis, we emphasize that the objective of the effort is not to use funds intended for the elderly as a method of subsidizing child-care services, but rather to achieve a mutual compatibility of interest in which the quality of child care available for a given cost is increased by drawing on the resources which older persons can provide and in which the welfare of older persons is increased through greater involvement in paid employment of a rewarding nature."

II. RECOMMENDATIONS

The study undertaken by Urban Systems on opportunities for using elderly in day-care centers reveals the important role that elderly workers can play as aides in varying capacities at day-care centers. This finding is all the more significant in light of the family assistance plan and other welfare alternatives that aid working as well as nonworking heads of families. A rapid expansion of day-care services will result in a serious shortage of staff and a frantic search for suitable aides. Unfortunately, unless there is a new emphasis on the value of elderly in child-care settings, they will be overlooked as a key source of personnel.

Some of the recommendations made for integrating the elderly into the operation of centers follow:

1. Develop facilities providing jobs and involvement in child-care services adjacent to or near housing for senior citizens, a step that could potentially provide the aged poor with job opportunities and save the Government money that otherwise must be spent for building or renovating facilities to house day-care centers.
2. Develop incentives for CDA's to use elderly workers under supplemental grants for day-care services.
3. Propose the creation of senior citizens cooperatives responsible for developing programs for the elderly in day care and provide the necessary capital.
4. Develop a special training program to provide the opportunity for senior citizens to fill the present shortages of administrative staff in day-care centers.
5. Demonstrate nontraditional forms of child-care services, such as evening and weekend services with senior citizen involvement.
6. Encourage the sponsoring agency to undertake the costs of sickness pay and associated health costs for the low-income elderly working in day-care centers.

OEO SUPPORT CONTRACT WITH NATIONAL COUNCIL ON AGING

As a means of improving and increasing programing for the elderly poor, OEO has contracted with the National Council on Aging (NCOA), since early 1965 to provide training and technical assistance. These services have helped focus at-

tention on the needs of the older poor, have increased the number of programs developed to meet this population's needs, and bolstered the capabilities of local, regional, and national groups to develop and operate services and projects aimed at assisting the elderly poor to achieve self-sufficiency.

The most recent contract with NCOA was let in September 1970 for $950,000 for a period of 1 year with a second year option to renew.

During 1970, NCOA conducted three regional training institutes involving a total of 887 participants, and including representatives from national, regional, State, and local level agencies. The focus of these institutes was on ways to effect greater resource mobilization at the community level for dealing with problems of the older poor. Planning meetings were held approximately 3 months prior to each institute and included representatives of agencies from each of the States participating. In addition to OEO, there were representatives from universities, voluntary agencies, State commissions on aging, State departments of health, and regional offices of Federal agencies.

In addition, NCOA participated in, sponsored, or shared sponsorship of a number of other training sessions at all levels during 1970. Training was provided for staffs of community action agencies, State technical assistance agencies, multipurpose training centers, and other segments of the OEO network. It was also conducted for public and voluntary agencies serving the elderly, representatives of senior centers, other practitioners in the field of aging, and members of the elderly poor population themselves. Focus was on increasing the capability of OEO to provide programs and services for the older poor, helping the elderly and their organizations to make greater use of antipoverty programs, and securing greater coordination between and cooperation with voluntary and governmental agencies to maximize the full, efficient use of all community resources for the elderly. Emphasis was on the practical, rather than the theoretical. Five national level, 17 regional level, 21 State level, and 48 local level training programs were carried out by NCOA involving a total of 11,191 persons.

A major element of the OEO–NCOA contractual agreement is the provision of technical assistance to Community Action Agencies and other local agencies with the goal of increasing services to and employment of older persons in OEO and other local programs. In a number of CAA's, percentage guidelines were instituted to insure proportional representation of older persons on CAA governing boards and policy committees. A total of 525 different technical assistance contacts and consultations were made to local-level agencies by NCOA's regional representatives during 1971. Better than half of those contacts were to CAA's.

In addition to technical assistance to CAA's, NCOA has worked with Indian CAA's and has developed many working programs and innovative activities for aged Indians, most notably in the Western region. At OEO's request, NCOA sent staff into the Hurricane Camille disaster area to assure service for the older poor. Emergency food and medical services programs were utilized to enable the elderly to find work and receive services.

Technical assistance has been offered to various components of Administration on Aging programs and NCOA has always maintained coordination and planning with the AOA. The Council also worked to effect maximum input by the older poor in planning for the 1971 White House Conference on Aging. NCOA met with members of OEO national staff as well as with regional and State people, CAA's, local senior citizen groups, and other agencies to plan for community forums, and has worked to effect greater participation by the older poor themselves in these planning efforts. In line with these efforts NCOA enlisted AOA's participation in all training efforts.

NCOA developed a roster of consultants, who functioned as speakers, analysts, and evaluators of programs for OEO, and who gave advice in areas where NCOA's representatives had limited experience. NCOA prepared and disseminated a great variety of materials in connection with its OEO contact, including program models, monographs, training papers, technical assistance guides, and a resource handbook.

An independent evaluation of OEO training and technical assistance activities completed some months ago rated NCOA's performance highly. The evaluation suggested that the pattern of operations and close working relationships between NCOA and OEO staff at both the national and regional levels could be used as a model for other contractors.

ITEM 11: OFFICE OF EDUCATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., January 18, 1971.

DEAR MR. CHAIRMAN: Thank you for your letter of November 25 requesting information on our activities in 1970 affecting the aging to be included in the report of the Special Committee on Aging, entitled, "Developments in Aging—1970."

I am enclosing statements with respect to the following programs administered in the Office of Education: Adult education; public library services; community services and continuing education; and manpower development and training.

Please let me know if I can be of further assistance.

Sincerely,

S. P. MARLAND, Jr.,
U.S. Commissioner of Education.

[Enclosures]

ADULT EDUCATION

The adult education program authorized under the Adult Education Act of 1966, as amended, provides instruction in essential skills—reading, writing, speech, comprehension, computation—up to and including the 12th-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, or they want to be better 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. The State must match 10 percent of the Federal share.

Two enclosures are included which describe the adult education program.

During fiscal year 1970, the reports of age distribution in appropriate adult education activities indicated the approximate extent to which persons over 45 years of age participated in the program.

*State grant program**

Age:	*Number of enrollees*
45 to 54	77,148
55 to 64	39,448
65 and over	15,100

*Teacher training program**

Age:	*Number of participants*
40 to 49	1,239
50 to 59	649
60 and over	261

*All figures based on fiscal year 1969 percentages as applied to estimated or adjusted fiscal year 1970 enrollment and participant reports.

PUBLIC LIBRARY SERVICES

The Division of Library Programs has, in the past year, supported the forthcoming White House Conference on Aging through planning with the Administration on Aging in representing the library's role for the coming Conference. The Division, besides its consultative function, has served to put professional library associations in touch with the Administration in preplanning phases of the Conference. Both representatives from the Administration on Aging and the Division have served jointly in consultative roles on professional library association committees dealing with services to an aging population.

The increasing number of aged persons in the library's public and their increasing educational levels have combined to foster a lively interest in library-sponsored programs: film series, oral history, poetry readings, book talks, reader's choice, storytelling for juniors by seniors. Too, senior citizens are partici-

pating within a whole range of more formal continuing education courses either sponsored or supported by public libraries through assistance contributed by the Library Services and Construction Act.

SERVICE DEVELOPMENTS

The possibility of some Federal assistance for institutional services and general services for handicapped people through public (and other) libraries supported by titles IV–A and IV–B has strengthened existent programs and permitted long-needed innovations in this area.

For example, one State agency, the Washington State Library whose institutional services are directed to 12,000 institutionalized residents, is now participating in the State's plan to move from solely institutional residential sites to halfway houses and local residential sites whose objective is to place these State dependents closer to a community setting. The Washington State Library is, with assisting Federal funds, responding to this shift in custodial and care philosophy by establishing nearby library services and by encouraging and promoting public library services to sustain the homebound and handicapped. In this shift, library services are becoming more available and more specifically aimed at the aged both through the program activities of the State government and through the leadership offered to public libraries striving to strengthen their services for senior citizens.

A new pattern of library service is growing that is ideal for aged persons. One of the first examples was that conducted under the leadership of the San Antonio (Texas) Library, assisted by foundation funds (Council on Library Resources) with the inauguration of books by mail to residents. Because such a service gives accessibility to the aged homebound the program was immediately useful. Two thousand requests a month by the telephone come into the library for books to be delivered through the mail services.

In a rural setting in Washington State, the North-Central Regional Library, began with Library Services and Construction Act assistance, mail services to a five-county area of 15,000 square miles. Patrons of the service regularly receive a newspaper-type publication that features new and interesting books that they may order by mail from the regional library. Older patrons say—"I could never get to a library because of our lack of transportation—new books arrive at our RFD mailbox." The director of the library is planning now, with the assistance of title I, LSCA funds, to add another county's mailboxes as the library's circulation desk. The Los Angeles Public Library continues to develop its services to the homebound, including the homebound aged, through mail service. Within the past year the public library intensified its efforts to reach Spanish-speaking residents who are shut-ins. Spanish language newspapers and television programs are now used to inform Spanish-speaking citizens of the shut-in program. The most effective means, however, that has been found is the use of Spanish-speaking library aides. The library believes that if it could more generally employ Spanish-speaking aides its successes with aged Spanish-speaking shut-ins could be greatly increased.

EDUCATION AND TRAINING

An encouraging aspect in development of heightened services is the special education and training programs aimed at developing and strengthening the competencies of library staff to work with senior citizens. An example of such continuing education was the seminar for 35 librarians conducted by Wayne State University. The Division of Library Programs through title II–B of the Higher Education Act funded the institute and in cooperation with the university furnished consultative advice on creating an inventory of library programs featuring services to aged persons.

Community Services and Continuing Education

Community service and continuing education programs, authorized by title I of the Higher Education Act of 1965, have established a number of programs designed to assist the older American. In 1970 a total of 7,360 persons participated in 20 programs developed for older Americans in 11 States.

Recognizing that early retirement and advances in medical science have afforded the senior citizen many years for useful activities, the title I program is attempting to find solutions to the problems which confront the older adult and to in-

crease 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 administrative 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 in nursing homes and homes for the elderly;

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; and

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. The title I 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 civil affairs; and courses to prepare women for leadership roles as volunteers.

Manpower Development and Training Program

(Public Law 87–415, as Amended)

Although occupational programs for persons over 45 have been available since the inception of the Manpower Development and Training Act of 1962, the 1966 amendments recognized the special requirements of the older worker in areas of training and employment.

In fiscal year 1970, participation of older workers in the MDTA program continued at about the same level as in previous years, with persons 45 years of age and older representing slightly below 10 percent of the enrollment among the total enrolled. Cumulatively (fiscal years 1963–70) the participation is slightly higher, at 11 percent of the total enrollment. Following is the report of participation for both institutional and on-the-job training for fiscal year 1970:

	Total	Institutional	OJT
Enrolled	226,000	135,000	91,000
45 years or older	22,200	13,100	9,100
Percent 45 years or older		9	10

Fact Sheet: The OE Program of Adult Education

LEGISLATION

Public Law 89–750, title III.—The Adult Education Act of 1966, as amended, was further amended by Public Law 91–230, title III. Cited in the law as the "Adult Education Act," this act authorizes appropriations of Federal funds for the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands. It also provides for discretionary grants to institutions of higher education, State or local educational agencies or other appropriate public or private agencies or organizations.

Purpose.—The purpose of the act is to establish or expand programs of adult public education so that adults can continue their education through completion of secondary school, and makes available the means to secure job training to help them become more employable, productive, and responsible citizens.

FUNDING

Congress determines the appropriations annually, based on authorizations in the act. Each State, in order to receive its allocation, must submit and obtain approval of a plan describing its present and future adult education needs and projected programs. Not less than 10 percent but not more than 20 percent of the total appropriation is reserved for special projects and teacher-training projects; 2 percent of the remainder is reserved for outlying territories; a $150,000 basic grant goes to each State and the District of Columbia, and the remainder is allotted to the States on the basis of a statutory formula which takes into account the number of adults who do not have a certificate of graduation from a secondary school, or the equivalent, and who are not currently required to be enrolled in school. The matching requirement for the State grant program is 90 percent Federal funds and 10 percent State or local funds. Special projects also have a matching requirement wherever feasible. There is no matching requirement for teacher-training projects. Total appropriations for fiscal year 1970: $49,900,000.

BASIC GRANTS

The States are allotted grants to pay the Federal share of the cost of establishing or expanding adult basic education programs and adult education programs in local educational agencies and private nonprofit agencies. Federal appropriations for State grants totaled $40 million in fiscal year 1970.

SPECIAL ADULT EDUCATION PROGRAMS

Federal appropriations available: Fiscal year 1970:

Special project grants, $7,900,000

Grants are made to local educational agencies or other public or private nonprofit agencies, including ETV stations, for special projects which promote comprehensive or coordinated approaches to the problems of adults who have not achieved a high-school diploma or its equivalent.

Teacher-training grants, $2 million

Grants are made to institutions of higher education, State or local educational agencies, or other public or private agencies or organizations to support training programs for adult education personnel and for persons preparing to work in adult education.

Enrollments	State grant program	Special projects	Teacher training
Year:			
1965	37,991	----	----
1966	378,000	----	982
1967	388,933	10,000	1,230
1968	455,730	39,300	2,075
1969	532,000	42,000	3,200

EXPENDITURES

Year	Federal funds	Total (Federal State and local funds)
State grants:		
1965	$4,168,836	$8,966,177
1966	34,122,227	44,041,132
1967	26,209,324	34,320,596
1968	30,583,882	39,612,885
1969	35,992,761	47,014,636
Special projects:		
1967	1,517,520	----
1968	6,550,000	----
1969	6,999,707	----
Teacher training:		
1966	1,055,000	----
1967	1,399,838	----
1968	1,500,000	----
1969	2,000,000	----

ADVISORY COUNCIL

The act requires the establishment of a National Advisory Council on Adult Education. The Council, consisting of 15 members appointed by the President, will advise the Commissioner, review the administration and effectiveness of the adult education programs, and report annually to the President on its findings and recommendations.

FOR FURTHER INFORMATION

Contact the Public Information Office, Bureau of Adult, Vocational, and Technical Education, U.S. Office of Education, HEW, room 5056, Regional Office Building No. 3, 7th and D Streets SW., Washington, D.C. 20202. Phone: (202) 963–5194 or 962–1166.

ITEM 12: POST OFFICE DEPARTMENT

POST OFFICE DEPARTMENT,
CHIEF POSTAL INSPECTOR,
Washington, D.C., January 8, 1971.

DEAR MR. CHAIRMAN: In response to your request of November 25, 1970, we are pleased to furnish for your consideration in preparing your annual report, "Developments in Aging—1970," the following information which may be of special interest or help to the older consumer.

The Chief Inspector's Department is responsible for the investigative enforcement of the mail fraud statute, section 1341, title 18, United States Code. It is the oldest consumer protection law, enacted by the Congress in 1872. It provides for a fine of $1,000 or 5 years' imprisonment, or both, for any use of the mails in furtherance of a scheme to obtain money or property on the basis of fraudulent representations.

Confidence in business transacted by mail is regarded as vital to the national welfare. It is the principal, if not the essential, artery of commerce and communication in this country. No elements of our society are immune to loss through mail fraud activity, and the businessman is quite as vulnerable as is the individual consumer. As in the case of all other types of criminal activity, mail fraud, the "white-collar crime" which leaves a trail of disillusionment and distrust in its wake, attacks the savings, and very frequently leaves the victim with a lengthy time payment contract to discharge, has shown a steady increase over the past several years. In fiscal year 1970, a total of 125,898 complaints were received. Arrests by postal inspectors totaled 1,163, and 910 convictions were returned; the latter two representing the highest in history and 6.8 and 18.6 percent, respectively, over 1969. Some 5,577 questionable promotions were terminated on the basis of our investigations and, although the mail fraud statute makes no specific provision for recoveries, a total of $3,797,188 was returned to victims or the public treasury in terms of restitution or fines.

As in the past, the types of fraudulent schemes encountered in our investigations range from the fly-by-night swindles designed for a quick kill to multimillion-dollar financial swindles carefully disguised behind complex corporate structures. All, of course, while they may not be specifically aimed at the elderly, affect them directly.

One so-called fly-by-night scheme was aimed at elderly persons having savings on deposit in savings and loan associations. A former savings and loan association employee obtained the names, addresses, and account numbers of elderly depositors, apparently by observation in lobbies, and mailed them letters claiming that an audit was being made and requesting that their passbooks be sent to a fictitious CPA at an address accessible to him. He also obtained signatures of depositors by including an offer of blue chip stamps, which had to be signed and returned. Subsequently, a withdrawal request was submitted to the savings and loan association in the name of the depositor for a substantial amount. The scheme was disclosed when a depositor brought a request for a passbook to the attention of a savings and loan association officer. While there was not public loss, the scheme, if successful, would have brought the depositors temporary inconvenience and possibly distress. As a result of prompt investigation by a postal inspector, the perpetrator of the scheme was quickly apprehended and pleaded guilty to mail fraud charges.

Another scheme in this category involved a would-be "get-rich-quick" individual who, using an assumed name, placed an advertisement in a well-known

numismatic trade paper offering to sell rare coins at unrealistically low prices. An answering service was used as a business address. Prompt investigation established the true identity of the operator and resulted in his being placed on probation for a period of 5 years. When arrested, the operator requested that all mail received addressed to him be returned to sender. Over 200 letters were returned, and it was estimated that they contained remittances amounting to $10,000. Terms of the probation included payment of a $6,500 fine and full restitution to all known victims' losses brought to the attention of the probation officer by postal inspectors. In this connection, it is estimated that hobbies are becoming another billion-dollar industry. Coin collection has, therefore, shown phenomenal growth in recent years among the country's leisure-minded citizens. This is attributed to the present-day coin shortage and the increase in value of numismatic and proof set coins. To protect coin collectors and deny the swindlers use of the mails, a program was established to pinpoint and coordinate this type of swindle. This program has been productive from a prosecutive standpoint and in many instances has been successful in suppressing an operation before it actually got started.

In a different type of a scheme, a physician in Chicago, Ill., was sentenced to 3 years' imprisonment and fined $15,000 for mail fraud and conspiracy. He and 10 others had been charged with defrauding numerous insurance companies, the Chicago Transit Authority, and the City of Chicago. The scheme involved personal claims which included excessive charges for medical attention; also, charges were made for nonexistent X-rays and treatment. Estimated loss to the public exceeded $1 million. It is an established fact that when insurance companies are defrauded or when large judgments are returned in favor of the insured, other insureds will experience in due course an increase in their premium rates to offset the insurance company's indemnity costs, which action is particularly felt by the elderly on reduced yearly incomes.

Following are summaries of several different types of mail fraud schemes which affect all parts of our society, especially the elderly.

Medical frauds.—Notwithstanding the establishment of modern medical facilities, both mobile and stationary in practically every community in the Nation many elderly people turn to and are victimized by medical quacks who advertise their cures or help for arthritis, baldness, cancer, overweight, lack of virility, headaches, etc. Possibly, the high costs of medical care and the absence of an adequate type of health insurance account for the decision of the aged to try such quick cures as seemingly lower costs.

Through a continuing cooperative investigation with officials of the State of California, Curtis H. Springer, age 72, was placed on 4 years' probation on November 9, 1970, for violations of the business and professions code (false advertising) and health and safety code (false advertising of drugs). The sentence also requires an audit for 1968 and 1969 regarding all mail order promotions; and to legally dissolve business by June 1, 1971. Since 1934, Springer's name has been a household word to hundreds of thousands of the ailing, the elderly, and the health food faddists throughout the Nation. Reportedly, Springer maintained advertisements for his products on 50 to 60 radio stations at a cost that sometimes reached $30,000 per month. It has been reported that many of Springer's products cost as little as 50 cents to produce and were sold for $10. Springer, who muted sincere commercial pitches with religious sermons and inspirational organ music, had used as his theme, "Eat Your Way to Health."

In October 1970, in Washington, D.C., a Federal court sentenced Marino J. Maturo, Louis P. Vecchiarello, and Anthony V. Vecchiarello each to 10 years' imprisonment. Maturo and the Vecchiarello brothers submitted false documents to obtain licenses to practice medicine in the District of Columbia. The documents purported to show the three had attended and graduated from Mexican Medical Schools; and as a result, they were granted licenses, opened offices in the District of Columbia, and treated numerous patients under the name of Southwest Medical Center. They became members of the District of Columbia medical society, obtained courtesy privileges at the Morris Cafritz Memorial Hospital, and also participated in group health and medicare programs.

Investment swindles.—This category includes the sale of stocks, bonds, oil and gas leases, investments in savings and loan associations, and related activities. The affluent American investor continues to supply a fertile field for the "shady" operator. During the year, 93 investigations were completed, resulting in the conviction of 55 promoters for mail fraud. These defendants received total prison terms of 291 years, 11 months, and total fines of $92,477. The savings

to the public as a result of cessation of these promotions is estimated at $2,428,938.

An investigation concluded during the past few months involved a 63-year-old couple at St. Louis, Mo., who used fictitious and fraudulent certificates of title, deeds of trust, and mortgage bonds, to obtain in excess of $400,000 from investors. Each was sentenced to 25 years' imprisonment.

Business opportunities.—Fraudulent "business opportunity" schemes represent one of the most important areas in our fraud investigative program. Four closely related promotions which fall under this general heading include distributorship, franchise, vending machine, and job opportunity frauds. Each year scores of elderly persons become prime targets for fast-talking salesmen who convince them to "put their savings to work and supplement their incomes." Investors are further lured with promises of high returns and money-back guarantees which later prove worthless.

A typical case in point was investigated by postal inspectors recently and resulted in the indictment of four individuals for mail fraud. Operating from Salt Lake City, Utah, the promoters sold purchase agreements for vending equipment and supplies to some 1,000 persons who were promised they would earn up to $800 per month. Most of the investors never received the equipment, and those that did earned little money from the poorly constructed machines which the company had placed in unsatisfactory locations. During the 3 years just passed, the venture resulted in a loss to the public of over $3 million.

Solicitation of funds.—A reliable source estimates that individuals gave $13.6 billion to various causes in 1969, of which $7.93 billion was given to religion and $2.85 billion to health and hospital care. The amount given is indicative of the success of organizations in convincing the public of the need for funds. While a vast majority of these organizations are serving worthy causes, experience has indicated that among the good there will be a few which make heart-rending appeals for funds and divert donations received to purposes other than those mentioned in the solicitation literature, or even for the personal enrichment of those associated with the organizations. Money given to such organizations defrauds the giver and those worthy organizations which would have properly used the funds. This Department recognizes the need for constant watchfulness to detect fraudulent operations in this manner and conducts investigations when appropriate. Because many elderly are of a compassionate disposition, they are among the victims of fraudulent fund-raisers.

Land sale swindles.—Concerted attention to these promotions by postal inspectors during recent years, resulting in many criminal prosecutions for mail fraud, has accomplished a drastic reduction in the number of such schemes with corresponding substantial savings to the public. Nevertheless, during the fiscal year ended June 30, 1970, there were 14 such cases completed, resulting in nine discontinued promotions, three convictions, and a savings of $1,960,000 to the public. Currently, there are 62 such cases under active investigation with 14 persons under criminal indictment.

One noteworthy investigation concluded during the year involved the sale of 60.125 acres of land wholly within the Great Smoky Mountains National Park, a Federal reservation, near Asheville, N.C. One of the two principals, an attorney, was found guilty of mail fraud and sentenced to 5 years' imprisonment, suspended, and was placed on 5 years' probation, fined $7,000, and ordered to surrender his law license. He certified to false title opinions to obtain title insurance and thus facilitate the sale. The other defendant was likewise found guilty of mail fraud and was sentenced to 10 years' imprisonment, suspended, placed on 5 years' probation and fined $8,000. The public loss is estimated at $1,250,000.

Matrimonial schemes.—This is an area where lonely people, including the elderly, are often swindled by dishonest persons. Lonely people seeking penpals with a view to finding suitable mates frequently join lonely heart clubs. Few, if any, of these clubs have facilities for investigating persons applying for membership and it is said that lists of members can be purchased with little or no difficulty. Club membership lists are, therefore, sometimes obtained by unscrupulous persons who use them to carry on extensive correspondence with prospective

victims. The correspondence is usually started by the promoters misrepresenting themselves to be exactly what the club members desire in mates. A glowing description is given of themselves, listing their likes and dislikes and stating they will come to see the club member. Sometimes a small photo is submitted with the first letter. As the correspondence progresses endearing terms are used and when the prospective victim mentions matrimony the promoters talk about current financial problems and request sums of money to carry them over the temporary crisis. Once the money is received the promoter usually fails to answer additional correspondence or returns the letters marked "Moved—left no address" or "Not here." Many victims fail to report the matter because of embarrassment.

Chain referral schemes.—The aged are especially susceptible to the appeals used in the chain referral method of selling. This technique has been used in promoting the sale of a variety of merchandise, such as home intercoms, burglary alarms, central vacuum cleaner systems, television sets, and the like, at highly inflated prices. Representations are made by salesmen to the effect that the selling firm advertises exclusively through word of mouth and passes savings on to them in the form of lower prices; that the merchandise or installation will not cost the prospect anything, as he can earn enough in commissions from referring others to the company to more than pay the installments on the item being sold. Many have come to realize, after signing sales contracts and being required to make regular monthly payments out of an already strained income for an overpriced item that was not really necessary, just how far-reaching the misrepresentations were. Convictions during the last few years in chain referral selling schemes appear to have lessened the popularity of this type of promotion somewhat. Additionally, several States have enacted legislation outlawing chain referral selling. Nevertheless, in fiscal 1970, investigations resulted in the conviction and sentencing of 10 persons. Forty-nine investigations were completed which indicated a public loss of $4,225,791. Investigation also resulted in the discontinuance of 39 promotions and an estimated public savings of $350,000.

One case in point was investigated at Danville, Va., where representatives of Eastern States Enterprises sold central vacuum cleaning systems on the referral plan at a cost to the customers of about $895, including interest on promissory note, while comparable systems were selling locally at $370 and $465. Buyers received few commissions. Four defendants were adjudged guilty and placed on probation.

Public education and fraud preventive programs.—The Department has continued to expand its program to prevent frauds through developing greater public awareness as to its danger signals. During fiscal year 1970, postal inspectors made over 1,300 speaking appearances before law enforcement, civic, educational, and consumer groups, as contrasted with approximately 1,200 the year before. Further, wide distribution was made of the mail fraud pamphlet, a copy of which was recently revised and is attached for your information.* Then, too, we continue to maintain close liaison and exchange mutually helpful data and intelligence with numerous agencies concerned with consumer protection, which we consider to be highly beneficial.

We are also cooperating in a new program initiated during 1970 by the Federal Trade Commisison in the field of consumer protection, whereby a law enforcement coordinating committee comprised of various agencies will be established in each of the major metropolitan areas of the Nation by means of which consumers' complaints will be channeled to the proper agency for prompt action. This activity is in line with the President's expressed deep concern for consumer protection programs.

I hope that the information contained in 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,

W. J. COTTER,
Chief Postal Inspector.

*Retained in committee files.

ITEM 13: SOCIAL AND REHABILITATION SERVICE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., January 12, 1971.

DEAR MR. CHAIRMAN: In response to your recent request, enclosed is a report on social and rehabilitation service activities affecting older Americans during 1970. It does not include a discussion of the activities of the Administration on Aging, one of our components, since it is our understanding that it will send you a report of its own.

We shall be pleased to hear from you if any additional information is needed.

Sincerely,

JOHN D. TWINAME,
Administrator.

[Enclosure]

SOCIAL AND REHABILITATION SERVICE ACTIVITIES AFFECTING THE ELDERLY DURING 1970

As shown by this report, the Administration on Aging is not the only component of the Social and Rehabilitation Service which carries on activities affecting older Americans. The old-age assistance program is one of the most important income maintenance mechanisms our society has been able to develop for its economically disadvantaged elderly. The medicaid program supplements medicare in meeting the health care needs of this segment of our population. SRS research and demonstration projects provide needed information and understanding regarding the elderly, as well as on other age groups. Rehabilitation services are provided the aged and others. SRS's Community Services Administration brings together under unified direction the provision of social services to individuals and families, including the aged. These various aspects of the work of SRS are discussed in this report.

OLD-AGE ASSISTANCE

In June 1970 SRS's Assistance Payments Administration served 2,052,000 persons aged 65 or over through the old-age assistance program. While this is a slight increase in number from the preceding year it represents a marked decrease from the alltime high of 2,810,000 old-age assistance recipients in September 1950. The overall decline has occurred because a larger proportion of the increasing aged population have become eligible for old-age, survivors, and disability insurance cash benefits, and because such benefits have been rising in amount. An additional factor contributing to the decline of persons receiving old-age assistance money payments is the development of the program for providing care in intermediate-care facilities for a large number of aged persons. In most instances, these aged do not receive money payments.

All 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have old-age assistance programs. The national average assistance grant in June 1970 was $74.75. This represents an increase of 6 percent (or $4.20) over the preceding year.

According to the latest study available the median age of old-age assistance recipients is approximately 77 years of age. The proportion of assistance recipients living alone in their own homes is approximately 35 percent. Approximately 27 out of every 100 aged persons receiving assistance require help from others in their daily living. More than two-thirds of the recipients are women.

As a means of encouraging dependent elderly people to attain either partial or full self-support, 39 States now provide for a disregard of some portion of earned income in determining the amount of assistance payments. Additionally, 29 States allow for some disregard of income which is incurred from sources other than earnings.

MEDICAL ASSISTANCE

Beginning January 1, 1970, all Federal support for medical assistance for the aged was provided under title XIX (medicaid). Medical assistance for the aged (MAA), also known as Kerr-Mills, and medical vendor payments under old-age assistance programs (OAA), ended December 31, 1969.

Seven States began title XIX programs on January 1, 1970, bringing the total of participants to 48 States and four jurisdictions. The remaining States, Alaska and Arizona, which have special problems because of their large Indian and indigenous populations, had not put medicaid into operation by the end of 1970.

Medical services provided by the State of Alaska are considered to be better than those of many title XIX States. Nursing home services are negotiated by the State with nursing homes, and eligibility is flexible. The Indian Health Service, caring for Indians and Eskimos, is reported to be good.

Arizona's public health services are sponsored by the individual counties, and neither care nor eligibility standards are uniform throughout the State. Services of the Indian Health Service are also described as uneven.

In fiscal year 1970, total expenditures for medical assistance under federally aided public assistance programs were $5.1 billion, of which $2.6 billion came from the Federal Government. About 40 percent of the total expenditures was spent on the aged. (These figures include the last 6 months of Federal expenditures under MAA and OAA, July 1–December 31, 1969.)

Medicaid permits the Federal Government to contribute to the cost of care for aged individuals in institutions for mental diseases when the State includes this service, and 35 States did so in fiscal year 1970. About 70,000 mental patients were enrolled in the program. The States involved received about $180 million of Federal funds to help them improve the care of patients and to develop comprehensive mental health programs.

Final regulations establishing standards to be met by skilled nursing homes in order to qualify for payments under medicaid were published in 1970, following publication of interim regulations in 1969. During the year interim regulations were published on State programs to license administrators of nursing homes, and on training programs to qualify administrators for licensure. In addition, proposed regulations were published on periodic medical review and medical inspections in skilled nursing homes and mental hospitals. The proposed regulations cover (1) a regular program of medical review including medical evaluation of each patient's need for skilled nursing home care or care in a mental institution; (2) periodic inspections in all skilled nursing homes and mental institutions serving medicaid patients, to evaluate the care being provided, the adequacy of the services available to meet the current health needs of each patient, the necessity and desirability of continued placement of such patients in such facilities, and the feasibility of alternate institutional or noninstitutional services; and (3) full and complete reports of findings by review teams.

RESEARCH AND DEMONSTRATIONS

Section 1115 projects

The demonstration projects program in public assistance under section 1115 of the Social Security Act provided grants for at least 24 different projects during the calendar year 1970 which were totally or partially concerned with providing a variety of services to elderly recipients in public welfare. These projects were carried out under the auspices of State public welfare agencies.

Two projects are providing housing assistance to the aged. The Kentucky Department of Economic Security together with the programs of the Office of Economic Opportunity, Department of Labor, Department of Agriculture, and Housing and Urban Development is carrying out a project in four counties in eastern Kentucky. The homes of 900 aged, blind, and disabled are being repaired to make them safe and suitable for occupancy, thus enabling the recipient to remain in his own home rather than being placed in a nursing home or institution. A model cities project in Georgia is demonstrating the coordination of various types of housing aids and resources made available to local communities through HEW and HUD programs to improve the housing of aged recipients.

In rural northern Alaska, the Department of Health, Education, and Welfare is experimenting with the use of human service aides to provide services to the aged which have previously never been available. The services include transportation to medical facilities, arranging for fuel oil to be provided and delivered, and homemaker help.

Two projects in consumer affairs are currently in operation. A project in Georgia is providing educational materials and help to the elderly as well as other low-income families and individuals. A project in Michigan is operating a consumer information center which provides consumer education, training information, and referral services for the elderly and low-income residents in a model city area.

A regional experiment involving two projects is demonstrating the coordinated and comprehensive delivery of social services to aged, blind, disabled and AFDC recipients. In Florida a one-stop information and referral center is coordinating

existing community services and developing new services while the project in New Jersey is operating a decentralized community organization in a suburban rural area to improve the delivery of such services as protective services, home management, housing, consumer education, etc.

Three neighborhood service center projects serving elderly recipients are conducting experiments to determine which services are most wanted and needed at the neighborhood level.

In one model city area the State public welfare agency is experimenting with the use of grandmothers and grandfathers in providing family day-care programs for AFDC children whose mothers are in training or employed.

A new model city project in Washington is operating a home management service center to provide such services as money management, housekeeping skills, and family management for aged and other public assistance recipients. Other States demonstrating the value of providing homemaker services are enthusiastic about the results which include helping the elderly remain in their homes or return to their homes following hospitalization. In all instances, the States experimenting with the provision of homemaker services have adopted the project activity into their ongoing program upon termination of the demonstration.

Vocational rehabilitation research and demonstration projects

A recently completed project evaluated a vocational rehabilitation program in which an intergenerational relationship was used as a therapeutic intervention. In this program older disabled workshop clients were assigned through a "buddy" system to young retarded adults to assist them in their initial adjustment to the workshop setting. The program proved successful and applicable to other settings.

A pilot project has completed a viable plan for a massive attack on the problems of aging through a system of industrial placement facilities for the aging in several locations of wide geographic distribution, with emphasis on poverty locations. Locations have been chosen and preliminary work done.

A demonstration center has been set up to show that the needs and talents of older workers can be matched with specific job requirements and the needs of the general economy. Local businessmen are cooperating with social scientists to provide and evaluate temporary placements in a work center leading to jobs which have been identified as those in which demand exceeds supply and job characteristics are ideally suited to characteristics of older workers.

REHABILITATION SERVICES

As the Federal partner in the State-Federal program of vocational rehabilitation, the Rehabilitation Services Administration encourages State rehabilitation agencies to provide necessary services to physically or mentally disabled, aging people so that they may be restored to gainful employment. The problems faced by the older worker in securing suitable employment are, of course, intensified when he suffers from a handicapping disability; and it is estimated that more than 4 million disabled individuals 40 years of age and over are in need of vocational rehabilitation services.

There has been a steady increase in the number of aging people served through the public program of vocational rehabilitation. In 1960, for example, a total of 88,275 disabled people were rehabilitated by the State rehabilitation agencies, and of these 25,674 were aged 45 or older. By 1970 the total number of rehabilitants had increased to 266,975, of whom an estimated 71,200 were aged 45 or over.

State rehabilitation agencies have utilized innovation grant and basic support resources to expand services for the aging disabled. For example, the Iowa rehabilitation agency has worked cooperatively with the Easter Seal Society in that State on a project for the homebound which serves a large number of older, disabled people. The Ohio agency has participated in a public housing project designed for the handicapped and senior citizens.

The Rehabilitation Services Administration has used its training grant authority to assist in program development for the aging. Long-term training grants in such fields as rehabilitation counseling, nursing, physical therapy, speech path-

ology and audiology, occupational therapy, and home economics yield benefits to the aging. For example, training in home economics includes home health care for the aging, home services for the aging in rural areas, and the preparation of specially designed clothing for the chronically disabled. Short-term training grants have also been used effectively by RSA in developing services for the aging. This resource was used, for example. to conduct a course on orthopedics and gerontology in cooperation with the American College of Orthopedic Surgeons. The purpose of this was to introduce young surgeons to surgical techniques particularly effective with the older orthopedic case. In the fall of 1970, RSA issued a short-term training grant to San Diego State University for the purpose of conducting a west coast conference on rehabilitation of the aging, with special emphasis on interagency coordination.

The Rehabilitation Services Administration cooperates with the Administration on Aging in such activities as senior citizens month and the foster grandparent program. At present, RSA staff are serving on several technical committees designated by AOA to plan the program for the White House Conference on Aging slated for 1971.

COMMUNITY SERVICES

The Community Services Administration. through its Division of Services to the Aged and Handicapped. is responsible for policy and program development of services to the needy aged and handicapped. It maintains liaison and joint planning on the operating levels with those Federal and National agencies and organizations active in the field of aging.

The estimated expenditures for the provision of social services to the needy aged are increasing substantially—over twice that spent in fiscal year 1969 is estimated for the current fiscal year.

	Expenditures for fiscal year 1970	Estimated expenditures for fiscal year 1971
Federal	$70,427,000	$90,121,000
State	27,818,000	33,446,000
Total	98,245,000	123,567,000

As of the quarter ending September 30, 1969 * some 222,000 aged persons received a variety of services which helped them with such problems as meeting health needs and requirements for home maintenance, securing employment, locating adequate housing, and finding opportunities to participate in community activities such as adult education and recreation. About one-third of the above number required the kind of services which would help them find protective institutional placements.

During the past year, the Community Services Administration completed the policy revision of its social services to the aged, blind, and disabled persons. This revision which was published in the Federal Register on November 26, 1970, provides further incentives for expanding service programs for the needy aged by permitting greater Federal matching for service related expenditures such as rent, office supplies, etc. For the first time, State welfare agencies providing services are required to establish advisory committees which will be charged with reviewing and making recommendations on the effectiveness of service policies. Membership on these committees must include representatives from the needy aged.

In addition to the above, steps have been taken (1) to ascertain the extent to which the services of other community agencies can be used to extend the scope and to improve the quality of "in-home" services for the aged and handicapped and (2) to evaluate the effectiveness of service programs in helping aged and disabled use health benefits available under Medicaid (title XIX).

*Last report available, since change in reporting is now being considered to reflect more accurately the extent of services provided.

ITEM 14: SOCIAL SECURITY ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C.

DEAR MR. CHAIRMAN: I am enclosing the statement on the developments in Social Security and Medicare during 1970 for your "Developments in Aging—1970." As you requested, it has been written in essentially the same form as the reports sent last year.

I hope this report meets your needs.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

[Enclosures]

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration administers the Federal retirement, survivors, disability, and health insurance programs (titles II, VII, XI, and XVIII of the Social Security Act, as amended) and the "black-lung benefit" provisions of the Federal Coal Mine Health and Safety Act of 1969. Social security coverage 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 95 million people contributed to social security in calendar year 1970. 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 January 1, 1970, had a face value of about $1,130 billion.

About 25.8 million men, women, and children were receiving monthly social security benefits as fiscal year 1970 ended. The beneficiaries include about 16.8 million retired workers and dependents of retired workers, 2.6 million disabled workers and their dependents, and 6.3 million survivors of deceased workers. About 0.6 million 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 1970 were receiving benefits or would be eligible to receive benefits when they or their spouses retire. Of those who reached 65 in 1970, 93 percent were eligible for social security cash benefits. Projections to the year 2000 indicate that 96 to 98 percent of all aged persons will then be eligible for cash benefits under the program.

What the program did in fiscal year 1970:

BENEFICIARIES AND BENEFIT AMOUNTS

During the fiscal year ended June 30, 1970, benefits paid under the old-age, survivors, and disability insurance program totaled $29,045 million—an increase of $2,869 million over the amount paid in the preceding fiscal year. Total benefit payments to disabled workers and their dependents were $2,778 million, 14 percent higher than in fiscal year 1969. Old-age and survivors insurance monthly benefits rose 11 percent to $26,267 million. Lump-sum death payments amounted to $288 million, about $2 million higher than in the previous fiscal year.

The number of monthly benefits in current-payment status increased by 0.8 million to 25.8 million during the fiscal year, and the monthly rate rose $453 million (21.0 percent) to $2.6 billion.

At the end of December 1969, the average old-age benefit being paid to a retired worker who had no dependents also receiving benefits was $117 a month. When the worker and his wife were both receiving benefits, the average family benefit was $169. For families composed of a disabled worker and a wife with one or more entitled children in their care, the average was $238; and

for families consisting of a widowed mother and two children, the average benefit was $256. The average monthly benefit for widows and widowers was $88. (Amendments effective January 1, 1970, raised benefits 15 percent.)

During the fiscal year, a period of disability was established for about 335,000 workers, 12,000 less than in fiscal year 1969. The number of persons determined to have been disabled since childhood totaled 25,000.

The number of disabled workers receiving monthly benefits rose 9 percent in the fiscal year and totaled 1,435,900 at the end of June. Benefits were being paid to about 1,131,600 wives, husbands, and children of these beneficiaries. By the end of June 1970, child's benefits were being paid at a monthly rate of $19.2 million to 263,500 disabled persons 18 and over—dependent sons or daughters of deceased, disabled, or retired insured workers—whose disabilities began before they reached 18. About 29,000 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 45,000 at the end of June 1970.

In July 1970 black-lung benefits were paid to about 22,400 beneficiaries. Their average monthly benefit was $167.

REPORT ON THE MEDICARE PROGRAM

In fiscal year 1970 medicare paid out $6.8 billion for the health care expenses of men and women aged 65 and over covered by the program. About $4.8 billion was paid for hospital care, extended care facility care, and other services covered by the hospital insurance program. In addition, $2 billion was reimbursed for physicians' services and various related health and medical items covered by the supplementary medical insurance program.

Medicare emerged in response to the basic dilemma that faced older people and private insurers in attempting to provide protection against the high cost of medical care in later life. The fundamental dilemma was that older people need much more medical care than the average younger person, but they could not afford to pay a premium high enough to cover the cost of care. Medicare established a hospital insurance plan, financed from payroll taxes, so that people pay toward this protection while at work without having to pay additional amounts after retirement. The supplementary medical insurance plan covers physicians' fees and other medical services, for which the individual paid $4 a month in 1970 and the Government matched his contribution with a like amount.

The two parts of the program provide for coverage of a wide variety of services, making it possible for the physician to choose the appropriate level of care for his patient. For example, the hospital insurance plan covers not only inpatient hospital care, but extended care for people who can leave the hospital but still need full-time nursing care, home health care for those who can be taken care of in their own homes but need the part-time services of visiting nurses or physical or speech therapy and other types of skilled medical care. Outpatient hospital care is covered under the medical insurance program as are physicians' services wherever performed—at home, in the doctor's office, a hospital, nursing home, etc. This coverage of a variety of services was designed to correct the situation that has existed in many other insurance plans that have put major emphasis on expensive inpatient hospital care.

Special provisions were also included in the program to emphasize the importance of quality care by requiring institutional providers of services to meet various standards. Special provisions for helping to control unnecessary hospital and extended care utilization were also included. All institutions are required to have utilization review committees and physicians must certify to the medical necessity of certain types of care and the continued need for hospital and extended care.

The basic design of the administration of the program has been to lodge the Federal responsibility in the Social Security Administration but to rely for the determination of reasonable costs and charges and for bill paying and reimbursement on intermediaries and carriers. These organizations are primarily Blue Cross and Blue Shield plans and private commercial insurance companies that previously had experience in the health insurance area.

Like other parts of the social security program this national system of health insurance for older people is an accepted part of American life and is generally recognized as contributing greatly to the health and security of our 20 million older citizens.

The accomplishments of medicare are well recognized. First of all, older people in this country are getting more hospital care than they received before medicare. This has not only extended lives but added quality to the lives of older people.

These people moreover receive medical care under conditions consistent with their self-respect and dignity. They go to hospitals as patients of their own personal physicians. The concept of charity care in a hospital hardly exists now for older people.

For many people medicare has meant access for the first time to the best hospitals. Members of minority groups have access to quality care on the same basis as everyone else. All the hospitals and extended care facilities and independent laboratories and other institutions that participate in medicare must meet standards of quality. This benefits everybody in the community, not just older people.

Older people now have a sense of security whether they have large medical bills or not in knowing that the possibility of a very expensive illness wiping out one's lifelong savings has been largely removed.

The medicare program depends for its success upon the understanding and cooperation of large numbers of people and a variety of institutions. Twenty million older people, just about all those over age 65, are covered under the hospital care portion of the program. Of these people, more than 95 percent have also signed up for the voluntary part of medicare and pay a monthly premium to get additional coverage for physicians' bills. Over 17 million hospital stays have been paid for during fiscal years 1968–70. Also during this same period, over 105 million medical bills have been paid under the supplementary plan.

There are about 6,800 hospitals involved, 200,000 physicians, and 4,650 extended care facilities (about 200 less than the previous year) in addition to 2,350 home health agencies, 2,680 private laboratories, and many other health service providers. Some 130 Blue Cross and Blue Shield and private insurance contractors help in the administration of the program and 52 State agencies are involved in the certification of eligibility of providers in terms of quality standards. The following presents statistical highlights of medicare for fiscal years 1968–70. Also included is more detailed information on use of hospital and medical services under the program. State data are reported for medicare reimbursements and for admissions to hospitals and extended care facilities.

MEDICARE STATISTICAL HIGHLIGHTS, FISCAL YEARS 1968–70

	Fiscal year		
	1968	1969	1970
Enrollment, Jan. 1 of fiscal year:			
Hospital insurance (pt. A)	19,700,000	19,900,000	20,200,000
Supplementary medical insurance (pt. B)	18,100,000	18,800,000	19,300,000
Participating providers of services (as of June 30 of fiscal year):			
Hospitals:			
Number	6,865	6,825	6,776
Beds	1,200,000	1,200,000	1,200,000
Home health agencies	2,093	2,209	2,350
Extended care facilities:			
Number	4,702	4,849	4,656
Beds	330,000	342,000	334,000
Independent laboratories	2,566	2,670	2,684
Amounts reimbursed:			
Hospital insurance (pt. A)	$3,700,000,000	$4,700,000,000	$4,800,000,000
Supplementary medical insurance (pt. B)	$1,400,000,000	$1,600,000,000	$2,000,000,000
Hospital and extended care facility admissions and home health plans established:			
Inpatient hospital admissions	5,767,000	6,061,000	6,116,000
Extended care facility admissions	435,000	515,000	470,000
Starts of home health plans	272,000	322,000	286,000
Medicare bills paid:			
Hospital insurance:			
Inpatient hospital	5,592,000	5,969,000	5,925,000
Outpatient hospital	665,000	41,000	
Extended care facilities	940,000	976,000	674,000
Home health services	434,000	564,000	589,000
Supplementary medical insurance:			
Physicians	24,518,000	30,279,000	32,680,000
Home health services	439,000	544,000	529,000
Outpatient hospital	3,544,000	3,387,000	3,701,000
Independent laboratory	400,000	536,000	621,000
All other	974,000	1,655,000	1,646,000

Admission and start of care rates

Fiscal year 1970 was characterized by the first decrease in the utilization of services provided under the hospital insurance program since medicare began. Although the number of admissions to inpatient hospitals rose slightly in 1969–70, the number of such admissions per 1,000 persons enrolled dropped from 307 in 1968–69 to 306 in 1969–70. For extended-care facility admissions both the number and rate fell with the rate showing a larger drop than that for inpatient hospitals, 23.5 admissions per 1,000 enrollees in 1969–70 compared with 26.1 in 1968–69. Rates for home health starts of care also fell, going from 16.3 per 1,000 enrollees in 1968–69 to 14.3 in 1969–70. Admission and start of care notice data, by State, are shown in table 1. It should be noted that the data shown in the table, as well as the comparisons discussed above, now reflect the actual period of admission or start of care and are not directly comparable to admission data shown in this report last year which reflected the period the admission or start of care was received by the Social Security Administration.

Medicare reimbursements

Reimbursements under the hospital insurance program, as well as under the supplementary medical insurance program, continued to rise during fiscal year 1970. Under the hospital insurance program (HI) the total increased from $4.7 billion in 1968–69 to $4.8 billion in 1969–70. The average reimbursement per enrollee also increased from $237 in 1968–69 to $241 in 1969–70. Reimbursements under the supplementary medical insurance program (SMI) rose from $1.6 billion in 1968–69 to $2 billion in 1969–70 while the average reimbursement per enrollee rose from $87 to $103 during the same period.

Tables 2 and 3 show total reimbursements and average reimbursements per enrollee under the HI and SMI programs, respectively, for fiscal years 1968–70. It should be noted that the State distributions of amounts reimbursed are based on the location of the part A intermediary or part B carrier making payments under medicare, not on the location of the provider of services or residence of the beneficiaries. Therefore, the per capita reimbursement shown for the States may differ slightly from those shown in other publications.

As in past years there continues to be a wide range of variation in the per capita reimbursements under the hospital insurance program between the individual States. In fiscal year 1970, this variation ranged from a low of $151 for South Carolina to a high of $325 for Nevada. For 24 States the average reimbursement per enrollee showed a decrease from the previous year. For the most part many of these decreases were attributable to a lower level of utilization of hospital insurance services as evidenced by a drop in both the admission and start of care rates and in the average length of stay per admission.

In spite of these decreases the pattern of interstate variation in reimbursements under the hospital insurance program continued to remain quite stable. As can be seen in table 3, States with high average per capita reimbursements in 1969–70 had high averages in previous years while those with low averages in 1969–70 had low averages in earlier years. This stability carries over to the regional pattern of reimbursement as well. The States in the Pacific and New England regions have consistently had the highest per capita reimbursements while those in the South Atlantic and East South Central regions have always been well below the national average.

Unlike the hospital insurance program, average per capita reimbursements under the supplementary medical insurance program during fiscal year 1970 rose in nearly all States, the exceptions being New Hampshire and Wyoming where the averages remained the same, and Alaska and New Mexico, where the averages fell. Per capita reimbursements under the SMI program also show a wide range of interstate variation which, during 1969–70, ranged from a low of $64 for Alabama to a high of $170 for California.

The pattern of interstate variability in per capita reimbursements under the SMI program shows the same year-to-year stability as is observed under the HI program. As can be seen in table 3, States in the Pacific and Middle Atlantic regions are consistently above the national averages while those in the East North Central and East South Central regions are consistently below.

The stability of the regional pattern in the averages for both parts of Medicare suggests that the underlying causes of State differences are also stable. These causes are related to:

1. Differences in the demographic composition of the aged population;
2. Differences in the availability of care in the form of hospital beds, doctors, and extended care facilities;
3. Differences in the cost of hospital and extended care facilities and in charges for physicians' and other medical services.

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 7.2 million hospital insurance (part A) claims recorded as of November 5, 1970, for fiscal year 1970, 82 percent were for inpatient hospital services, 9 percent for extended care services, and nearly all of the remainder for home health services (table 4). The small number and proportion of claims for outpatient diagnostic services during the past 2 years reflects the change in the law which switched the coverage of such services from the hospital insurance program to the supplementary medical insurance program effective April 1, 1968. Reimbursements for inpatient care totaled $4.1 billion and averaged $691 per claim. Reimbursements for extended care facility and home health claims during the year averaged $364 and $78, respectively.

Table 5 presents the number of claims for inpatient hospital care approved for payment, the covered days of care, total charges, and amounts reimbursed for fiscal years 1968–70. During fiscal year 1970, the number of claims, covered days of care, and average days per claim all showed a decrease from the previous year, again illustrating the lower level of utilization of health insurance services cited earlier. The total charges per claim and the average charges per day of care, however, continued to show substantial increases. Since fiscal year 1967, the first year the program was in operation, the average charges per covered day of care have risen from $45 a day to $69.

Reimbursements for short-stay hospital care represented about 78 percent of total charges in fiscal year 1970, compared with about 80 percent in previous years. The amounts reimbursed represent payments for covered services, based on an interim rate and adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation. Amounts reimbursed exclude deductibles and coinsurance payments and noncovered services as specified by law.

Under the supplementary medical insurance program (part B), a total of 39.2 million paid bills were recorded during fiscal year 1970. Of these, 83 percent were for physicians' services, 9 percent for outpatient hospital care, and the remainder for home health, independent laboratory, and other medical services (table 6). Total allowed charges for these bills amounted to $2.4 billion, or an average of $61 per bill. For physicians' services, allowed charged average $66 per bill, for home health bills they averaged $70, for outpatient bills $31, and for independent laboratory bills $19.

Of the 32.7 million bills for physicians' services, 14 percent for surgical procedures and 86 percent were for medical care. Allowed charges for surgical bills totaled $766 million and averaged $163 per bill while for medical bills they totaled $1.4 billion and averaged $49 per bill (table 7).

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, 1969 TO JUNE 30, 1970 [1]

Region, census division, and State	Inpatient hospital admissions		Extended care facility admissions		Home health start of care [2]	
	Number (thousands)	Per 1,000 enrollees [3]	Number (thousands)	Per 1,000 enrollees [3]	Number (thousands)	Per 1,000 enrollees [3]
Total, all areas [4]	6,116.1	305.6	470.2	23.5	286.0	14.3
United States [5]	6,075.0	306.2	469.4	23.7	285.2	14.4
Regions: [6]						
Northeast States	1,321.7	254.3	111.9	21.5	101.7	19.6
North Central States	1,802.4	314.2	110.8	19.3	65.2	11.4
South	1,998.3	341.4	108.8	18.6	64.7	11.1
West	952.6	313.0	137.9	45.3	53.6	17.6
New England	353.5	277.8	33.7	26.5	31.6	24.8
Maine	38.3	320.2	3.0	25.1	2.6	21.7
New Hampshire	23.7	292.6	1.6	19.8	2.3	28.4
Vermont	15.7	318.5	.7	14.2	1.6	32.5
Massachusetts	179.6	284.0	15.5	24.5	15.3	24.2
Rhode Island	25.5	245.7	3.1	29.9	3.2	30.8
Connecticut	70.7	246.9	9.8	34.2	6.6	23.1
Middle Atlantic	968.2	246.7	78.2	19.9	70.1	17.9
New York	473.3	240.5	35.5	18.0	32.7	16.6
New Jersey	158.2	229.8	18.7	27.1	14.1	20.5
Pennsylvania	336.6	265.3	24.0	18.9	23.3	18.4
East North Central	1,104.3	289.4	80.4	21.1	43.8	11.5
Ohio	270.2	272.4	24.0	24.2	15.6	15.7
Indiana	137.3	278.7	10.7	21.7	4.7	9.5
Illinois	329.6	301.1	21.8	19.9	9.2	8.4
Michigan	217.0	284.4	15.6	20.4	8.6	11.3
Wisconsin	150.2	317.0	8.3	17.5	5.7	12.0
West North Central	698.1	363.4	30.4	15.8	21.4	11.1
Minnesota	153.0	371.4	8.8	21.4	6.3	15.3
Iowa	124.2	351.3	7.1	20.1	2.1	5.9
Missouri	187.9	337.0	6.7	12.0	8.9	16.0
North Dakota	32.2	476.3	.5	7.4	.4	5.9
South Dakota	33.2	409.4	1.2	14.8	.8	9.9
Nebraska	68.3	372.6	3.1	16.9	1.1	6.0
Kansas	99.3	373.2	3.0	11.3	1.8	6.8
South Atlantic	869.9	311.5	55.5	19.9	26.9	9.6
Delaware	10.9	243.8	.9	20.1	1.0	22.4
Maryland	64.0	222.5	7.1	24.7	2.8	9.7
District of Columbia	20.7	311.3	.7	10.5	1.8	27.1
Virginia	105.5	293.8	6.8	18.9	3.3	9.2
West Virginia	71.0	360.0	2.2	11.2	2.5	12.7
North Carolina	130.5	319.1	5.9	14.4	2.2	5.4
South Carolina	57.1	301.2	3.2	16.9	2.3	12.1
Georgia	121.7	338.1	5.1	14.2	2.3	6.4
Florida	288.5	328.4	23.6	26.9	8.7	9.9
East South Central	439.4	348.2	25.5	20.2	13.7	10.9
Kentucky	114.1	338.0	8.0	23.7	4.4	13.0
Tennessee	137.8	361.8	8.8	23.1	3.2	8.4
Alabama	106.5	330.6	5.0	15.5	4.1	12.7
Mississippi	81.0	366.2	3.7	16.7	2.0	9.0
West South Central	689.0	382.9	27.8	15.4	24.1	13.4
Arkansas	89.3	381.1	2.2	9.4	1.6	6.8
Louisiana	107.2	356.7	2.7	9.0	6.2	20.6
Oklahoma	112.7	384.0	4.4	15.0	3.3	11.2
Texas	379.8	391.1	18.5	19.1	13.0	13.4

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, 1969 TO JUNE 30, 1970 [1]—Continued

Region, census division, and State	Inpatient hospital admissions		Extended care facility admissions		Home health start of care [2]	
	Number (thousands)	Per 1,000 enrollees [3]	Number (thousands)	Per 1,000 enrollees [3]	Number (thousands)	Per 1,000 enrollees [3]
Mountain	247.6	362.1	18.2	26.6	10.2	14.9
Montana	30.6	439.7	1.2	17.2	.6	8.6
Idaho	22.4	327.5	2.5	36.5	1.1	16.1
Wyoming	11.9	386.4	.3	9.7	.3	9.7
Colorado	74.8	400.0	5.9	31.6	3.1	16.6
New Mexico	23.1	324.9	1.3	18.3	.9	12.7
Arizona	52.1	346.6	4.3	28.6	2.9	19.3
Utah	22.0	289.1	1.6	21.0	1.0	13.1
Nevada	10.7	352.0	1.1	36.2	.3	9.9
Pacific	705.0	298.8	119.7	50.7	43.4	18.4
Washington	104.6	327.1	13.8	43.2	4.6	14.4
Oregon	68.3	305.2	9.0	40.2	4.0	17.9
California	517.9	293.3	95.6	54.1	34.0	10.3
Alaska	1.7	257.6	(7)	.....	(7)	.....
Hawaii	12.5	285.4	1.3	29.7	.8	18.3
Outlying areas	41.1	237.2	.8	4.6	.8	4.6
Unknown	(7)	.....	(7)	.....	(7)	.....

[1] Data reported reflect the actual date of admission (or start of care) and are based on admission (or start of care) notices received and processed by the Social Security Administration through October 1970. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional notices of admission or start of care in 1969–70 are received and processed by the Social Security Administration.

[2] Includes home health start of care notices under both hospital insurance and medical insurance.

[3] Based on enrollment data for the hospital insurance program as of Jan. 1, 1970.

[4] Includes Puerto Rico, the Virgin Islands, and other outlying areas.

[5] Includes unknown.

[6] 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; and West includes Mountain and Pacific States.

[7] Less than 50.

TABLE 2.—HOSPITAL INSURANCE: TOTAL AND AVERAGE REIMBURSEMENT PER ENROLLEE, BY REGION, DIVISION, AND STATE, FISCAL YEARS 1968–70

Area	1968		1969		1970	
	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]
Total [2]	$3,736,322	$192	$4,653,976	$236	$4,804,243	$240
United States	3,727,257	193	4,638,816	237	4,789,819	241
Regions:						
Northeastern States	1,054,856	206	1,329,397	258	1,362,611	262
North Central States	1,110,646	196	1,339,117	235	1,393,799	243
South	903,541	161	1,131,675	197	1,196,825	204
West	658,215	226	838,627	281	836,581	275
New England	303,849	242	368,938	292	358,571	282
Maine	22,284	189	27,063	228	25,462	213
New Hampshire	12,453	158	18,187	227	16,379	202
Vermont	7,665	158	10,701	219	11,688	237
Massachusetts	161,000	256	196,505	312	198,185	313
Rhode Island	20,166	198	31,576	307	29,747	287
Connecticut	80,280	287	84,906	300	77,110	269
Middle Atlantic	751,007	194	960,459	247	1,004,040	256
New York	411,358	211	545,545	279	570,959	290
New Jersey	121,476	181	150,864	222	154,081	224
Pennsylvania	218,172	174	264,050	210	279,000	220

TABLE 2.—HOSPITAL INSURANCE TOTAL AND AVERAGE REIMBURSEMENT PER ENROLLEE, BY REGION, DIVISION, AND STATE, FISCAL YEARS 1968–70—Continued

Area	1968		1969		1970	
	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]
East North Central	$760,430	$202	$917,098	$242	$943,692	$247
Ohio	181,537	185	212,843	216	226,761	229
Indiana	81,861	168	102,333	209	108,123	219
Illinois	235,010	217	305,008	280	292,132	267
Michigan	170,292	229	188,075	249	208,759	274
Wisconsin	91,730	198	108,839	232	107,971	228
West North Central	350,215	184	422,019	220	450,107	234
Minnesota	92,915	229	109,418	267	109,470	266
Iowa	59,039	168	72,235	204	77,334	219
Missouri	98,312	179	117,904	212	137,112	246
North Dakota	12,918	195	17,434	260	17,720	262
South Dakota	13,931	173	16,585	205	17,201	212
Nebraska	28,037	155	34,510	189	35,680	195
Kansas	45,064	171	53,933	203	55,590	209
South Atlantic	442,969	168	555,971	205	576,849	207
Delaware	7,725	179	9,038	206	11,125	249
Maryland	49,111	179	59,899	213	63,522	221
District of Columbia	16,499	243	24,992	372	27,745	417
Virginia	51,982	151	62,317	177	70,731	197
West Virginia	28,533	146	34,380	175	36,594	186
North Carolina	54,000	138	72,440	181	72,685	178
South Carolina	22,181	122	30,500	164	28,685	151
Georgia	47,220	135	59,794	169	60,484	168
Florida	165,718	210	202,611	243	205,278	234
East South Central	175,537	143	223,984	180	234,300	186
Kentucky	48,500	146	60,042	179	58,153	172
Tennessee	58,570	159	76,085	203	79,675	209
Alabama	43,593	140	54,400	172	58,570	182
Mississippi	24,874	115	33,457	153	37,902	171
West South Central	285,034	164	351,720	199	385,676	214
Arkansas	29,768	131	33,491	145	37,812	161
Louisiana	36,809	126	53,424	181	59,792	199
Oklahoma	47,090	165	55,091	190	58,219	198
Texas	171,367	184	209,714	220	229,853	237
Mountain	132,403	205	163,013	245	157,650	234
Montana	14,305	209	16,000	231	14,673	211
Idaho	10,205	155	12,545	187	12,730	186
Wyoming	4,918	163	5,380	177	5,676	185
Colorado	43,194	237	52,958	287	50,895	272
New Mexico	10,795	163	12,646	184	12,919	182
Arizona	31,037	233	38,422	271	39,355	262
Utah	10,664	148	13,702	185	13,502	177
Nevada	7,285	271	11,360	397	9,900	325
Pacific	525,812	232	675,614	292	676,931	287
Washington	64,055	206	71,620	227	72,504	227
Oregon	41,001	191	48,250	220	47,675	213
California	411,390	243	543,737	314	544,039	308
Alaska	572	95	1,004	161	1,663	254
Hawaii	8,793	218	11,003	261	11,050	252

[1] Based on January 1 enrollment.
[2] Includes Puerto Rico the Virgin Islands, and other outlying areas.

TABLE 3.—SUPPLEMENTARY MEDICAL INSURANCE: TOTAL AND AVERAGE REIMBURSEMENT PER ENROLLEE, BY REGION, DIVISION, AND STATE, FISCAL YEARS 1968–70

Area	1968		1969		1970	
	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]
Total [2]	$1,389,622	$77	$1,644,842	$87	$1,979,288	$103
United States	1,385,301	77	1,638,689	87	1,971,779	103
Regions:						
Northeastern States	411,318	85	461,882	93	547,098	109
North Central States	324,333	62	391,214	71	465,406	84
South	357,972	70	449,610	83	537,911	95
West	291,679	107	335,983	117	421,364	142
New England	90,725	76	99,969	81	119,007	96
Maine	5,636	50	6,732	58	7,980	68
New Hampshire	4,239	58	6,174	81	6,277	81
Vermont	2,736	59	3,026	64	3,915	81
Massachusetts	50,679	84	51,301	84	62,921	102
Rhode Island	6,720	70	10,290	104	11,811	117
Connecticut	20,715	77	22,446	81	26,103	93
Middle Atlantic	320,593	88	361,913	97	428,091	113
New York	189,036	103	198,789	106	235,796	124
New Jersey	53,928	84	66,268	100	75,544	112
Pennsylvania	77,578	67	96,856	80	116,751	95
East North Central	210,414	60	258,935	71	305,613	83
Ohio	49,501	55	63,024	67	81,427	85
Indiana	24,899	56	29,484	63	33,398	70
Illinois	64,736	64	80,439	77	85,663	81
Michigan	46,085	66	55,984	77	68,647	93
Wisconsin	25,193	58	30,004	66	36,478	79
West North Central	113,919	65	132,279	72	159,793	86
Minnesota	29,156	76	34,042	86	39,675	98
Iowa	20,355	61	18,402	54	24,055	70
Missouri	34,141	70	39,974	75	47,635	88
North Dakota	4,112	67	4,492	70	5,485	84
South Dakota	3,715	50	4,152	54	5,201	66
Nebraska	10,803	65	12,663	72	16,633	94
Kansas	11,637	48	18,554	73	21,109	82
South Atlantic	180,422	75	225,060	87	276,871	103
Delaware	2,903	72	3,218	76	3,795	88
Maryland	14,393	59	18,604	72	23,932	89
District of Columbia	7,282	121	8,183	132	10,272	163
Virginia	19,141	62	22,875	69	29,282	86
West Virginia	9,985	56	15,043	80	16,048	84
North Carolina	18,756	54	20,929	56	26,370	67
South Carolina	7,905	48	10,230	59	11,928	66
Georgia	18,125	57	21,768	64	29,601	85
Florida	81,932	110	104,210	129	125,643	147
East South Central	59,216	54	78,098	67	90,455	74
Kentucky	14,709	48	22,174	69	24,884	76
Tennessee	20,165	59	22,472	62	28,847	78
Alabama	15,731	56	18,703	63	19,957	64
Mississippi	8,611	49	14,749	77	16,767	80
West South Central	118,335	74	146,452	87	170,585	98
Arkansas	10,362	49	12,846	58	15,737	70
Louisiana	13,940	55	19,840	74	23,715	86
Oklahoma	23,002	86	25,155	90	28,769	101
Texas	71,030	81	88,611	96	102,364	108

TABLE 3.—SUPPLEMENTARY MEDICAL INSURANCE: TOTAL AND AVERAGE REIMBURSEMENT PER ENROLLEE, BY REGION, DIVISION, AND STATE, FISCAL YEARS 1968–70—Continued

Area	1968		1969		1970	
	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]
Mountain	$49,540	$83	$58,869	$93	$70,160	$106
Montana	4,417	69	4,739	71	5,556	82
Idaho	3,778	63	4,660	72	5,814	88
Wyoming	1,636	59	2,037	70	2,072	70
Colorado	15,591	90	18,590	104	22,522	123
New Mexico	4,010	70	5,871	96	6,013	91
Arizona	13,998	113	14,457	107	18,466	128
Utah	4,332	65	5,250	74	6,070	83
Nevada	1,777	72	3,265	121	3,647	125
Pacific	242,139	114	277,114	124	351,204	153
Washington	21,050	72	26,466	87	31,146	100
Oregon	14,191	72	16,723	80	20,943	98
California	202,698	127	228,512	136	292,875	170
Alaska	237	53	537	109	494	92
Hawaii	3,962	104	4,876	119	5,746	134

[1] Based on Jan. 1 enrollment.
[2] Includes Puerto Rico, the Virgin Islands, and other outlying areas.

TABLE 4.—HOSPITAL INSURANCE: NUMBER OF CLAIMS APPROVED FOR PAYMENT AND AMOUNTS REIMBURSED BY TYPE OF BENEFIT, FISCAL YEARS 1968–71 [1]

Type of benefit	1968		1969		1970	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Approved claims (number in thousands):						
Total	7,632	100.0	7,550	100.0	7,188	100.0
Inpatient hospital	5,592	73.3	5,969	79.1	5,925	82.4
Outpatient diagnostic [2]	665	8.7	41	.5	[3]	
Extended care facility	940	12.3	976	12.9	674	9.4
Home health	434	5.7	564	7.5	589	8.2
Amount reimbursed [4] (amount in millions):						
Total	$3,473.9	100.0	$4,216.7	100.0	$4,387.8	100.0
Inpatient hospital	3,132.9	90.2	3,824.8	90.7	4,096.4	93.4
Outpatient diagnostic [2]	7.8	.2	.6	[5]	[5]	
Extended care facility	302.8	8.7	348.3	8.3	245.4	5.6
Home health	30.3	.9	43.1	1.0	46.0	1.0
Amount reimbursed per claim:						
Inpatient hospital	$560		$641		$691	
Outpatient diagnostic [2]	12		14		14	
Extended care facility	322		357		364	
Home health	70		76		78	

[1] Data for 1968 reflect claims approved and recorded in the Social Security Administration central records before Dec. 31, 1969. Data for 1969 and 1970 reflect claims approved and recorded in the Social Security Administration central records before Nov. 5, 1970.
[2] Outpatient diagnostic services were covered under the hospital insurance plan prior to Apr. 1, 1968, at which time such services were covered only under the medical insurance plan. Thus amounts shown under hospital insurance in fiscal years 1969 and 1970 reflect reimbursement for claims approved for payment in the period but for services rendered prior to Apr. 1, 1968.
[3] Less than 500.
[4] Amounts shown represent payments for covered services based on an interim rate and are adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation. Payments exclude deductible and coinsurance amounts and noncovered services as specified by law.
[5] Less than 0.05 percent.
[6] Less than $50,000.

TABLE 5.—HOSPITAL INSURANCE: NUMBER OF CLAIMS FOR INPATIENT HOSPITAL CARE APPROVED FOR PAYMENT, COVERED DAYS, TOTAL CHARGES AND AMOUNTS REIMBURSED, BY TYPE OF HOSPITAL, FISCAL YEARS 1967–70

Fiscal year	Number of claims[1] (in thousands)	Covered days of care		Charges				
				Total			Reimbursements[2]	
		Total (in thousands)	Average per claim	Amount (in millions)	Per claim	Per day	Amount (in millions)	Percent of total
All hospitals:[3]								
1967	4,596	61,682	13.4	$2,783.6	$606	$45	$2,236.8	80.4
1968	5,592	75,208	13.4	3,916.3	700	52	3,132.9	80.0
1969	5,969	80,177	13.4	4,786.6	802	60	3,824.8	79.9
1970	5,925	76,149	12.9	5,261.5	888	69	4,096.4	77.9
Short stay:								
1967	4,498	58,584	13.0	2,719.6	605	46	2,183.0	80.3
1968	5,466	71,517	13.1	3,829.2	701	54	3,065.9	80.1
1969	5,822	76,280	13.1	4,674.7	803	61	3,744.3	80.1
1970	5,827	73,356	12.6	5,169.2	887	70	4,029.5	78.0
Long stay:[4]								
1967	81	2,900	35.9	56.6	702	20	48.5	85.6
1968	98	3,398	34.7	75.2	768	22	58.7	78.1
1969	115	3,556	30.8	96.8	839	27	71.6	74.0
1970	95	2,770	29.0	91.2	956	33	66.2	72.6

[1] Data for 1967 and 1968 reflect claims approved and recorded in the Social Security Administration central records before Dec. 31, 1969. Data for 1969 and 1970 reflect claims approved and recorded in the Social Security Administration central records before Nov. 5, 1970.

[2] Amounts shown represent payments for covered services based on an interim rate and are adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation. Payments exclude deductibles and coinsurance amounts and noncovered services as specified by law.

[3] Includes claims with type of hospital unknown.

[4] General and special hospitals reporting average stays of 30 days or more: tuberculosis, psychiatric, and chronic disease hospitals, and Christial Science sanatoria.

TABLE 6.—SUPPLEMENTARY MEDICAL INSURANCE: NUMBER OF REIMBURSED BILLS FOR PHYSICIANS' AND RELATED MEDICAL SERVICES, TOTAL CHARGES, AND AMOUNT PER BILL, BY TYPE OF SERVICE, FISCAL YEARS 1968–70[1]

Type of service	1968		1969		1970	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
	Bills (number in thousands)					
All services[2]	30,153	100.0	36,439	100.0	39,197	100.0
Physicians	24,518	81.3	30,279	83.1	32,680	83.4
Home health	439	1.5	544	1.5	529	1.3
Outpatient hospital	3,544	11.8	3,387	9.3	3,701	9.4
Independent laboratory	400	1.3	536	1.5	621	1.6
All other	974	3.2	1,655	4.5	1,646	4.2
	Charges[3] (amount in millions)					
All services[2]	$1,727.6	100.0	$2,249.7	100.0	$2,394.3	100.0
Physicians	1,580.2	91.5	2,029.3	90.2	2,148.2	89.7
Home health	24.9	1.4	35.8	1.6	37.2	1.6
Outpatient hospital	46.1	2.7	92.5	4.1	114.2	4.8
Independent laboratory	8.5	.5	10.6	.5	12.0	.5
All other	46.7	2.7	79.0	3.5	81.8	3.4
	Charges per bill					
All services[2]	$57		$62		$61	
Physicians	64		67		66	
Home health	57		66		70	
Outpatient hospital	13		27		31	
Independent laboratory	21		20		19	
All other	48		48		50	

[1] Includes only those bills for which reimbursements were made by carriers and intermediaries and which were recorded in the Social Security Administration central records before July 9, 1970.

[2] Includes some bills and their charges for which type of service is unknown.

[3] Except for outpatient hospital and home health services, represents allowed charges as determined by the carriers on the basis of customary charges for similar services generally made by the physician or supplier of covered services, and also on prevailing charges in the locality for similar services. Charges for outpatient hospital and home health bills are the amounts actually billed by providers.

TABLE 7.—SUPPLEMENTARY MEDICAL INSURANCE: NUMBER OF REIMBURSED BILLS FOR PHYSICIANS' AND RELATED MEDICAL SERVICES, TOTAL CHARGES, AND REIMBURSED AMOUNT, BY TYPE OF BILL, FISCAL YEARS 1968–70 [1]

Fiscal year	Bills		Charges					
			Total [2]			Reimbursement [3]		
	Number (in thousands)	Percent distribution	Amount (in millions)	Percent distribution	Per bill	Amount (in millions)	Percent distribution	Percent of total
All bills: [4]								
1968	30,153	100.0	$1,727.6	100.0	$57	$1,246.8	100.0	72.2
1969	36,439	100.0	2,249.7	100.0	62	1,623.7	100.0	72.2
1970	39,197	100.0	2,394.3	100.0	61	1,736.3	100.0	72.5
Surgical bills:								
1968	3,221	10.7	535.0	31.0	166	402.4	32.3	75.2
1969	4,115	11.3	672.1	29.9	163	504.3	31.1	75.0
1970	4,702	12.0	765.9	32.0	163	577.0	33.2	75.3
Medical bills:								
1968	21,297	70.6	1,045.3	60.5	49	740.1	59.4	70.8
1969	26,165	71.8	1,357.2	60.3	52	966.2	59.5	71.2
1970	27,978	71.4	1,382.3	57.7	49	988.2	56.9	71.5

[1] Includes only those bills for which reimbursements were made by carriers and intermediaries and which were recorded in the Social Security Administration central records before July 9, 1970.

[2] Except for outpatient hospital and home health services, represents allowed charges as determined by the carriers on the basis of customary charges for similar services generally made by the physician or supplier of covered services, and also on prevailing charges in the locality for similar services. Charges for outpatient hospital and home health bills are the amounts actually billed by providers.

[3] Represents 80 percent of allowed charges once the beneficiary has satisfied the $50 deductible in the current year. Some radiology and pathology services are reimbursed at a 100-percent rate regardless of the beneficiary's deductible status.

[4] Includes bills for home health, outpatient hospital, independent laboratory, and other services covered under the medical insurance program, as well as some bills for which type of service is unknown.

ITEM 15: SPECIAL ASSISTANT TO THE PRESIDENT FOR CONSUMER AFFAIRS

THE WHITE HOUSE,
Washington, January 18, 1971.

DEAR SENATOR WILLIAMS: I am pleased to send you and the Special Committee on Aging a report on the activities on behalf of the aged which my office, the President's Committee on Consumer Interests, has engaged in during 1970.

"Developments in Aging—1970," which you are preparing and for which my comments were solicited, will be of great benefit to the elderly. I salute you for your efforts on behalf of this segment of our population.

Sincerely,

VIRGINIA H. KNAUER,
Special Assistant to the President for Consumer Affairs.

[Enclosure]

REPORT ON 1970 ACTIVITIES OF THE PRESIDENT'S COMMITTEE ON CONSUMER INTERESTS RELATING TO THE AGING

LEGISLATIVE AND ADMINISTRATIVE PROPOSALS

The administration's 1970 consumer legislative proposals, which were prepared by the President's Committee on Consumer Interests, and which Mrs. Knauer actively supported, consisted of a package of five bills providing protection to the elderly and all other consumers. These bills were: The Consumer Representation Act, the Consumer Protection Act, the Consumer Product Testing Act, the Drug Identification Act, and the Consumer Warranty Act.

The Consumer Representation Act provided for the establishment of a statutory Office of Consumer Affairs in the Executive Office of the President, giving every American consumer, including the aged, a permanent voice in the White House. The Consumer Representation Act also provided for the creation of a 20-member Consumer Advisory Council of experts to advise the President on consumer matters. The bill furthermore called for the creation of a new Consumer Protection Division in the Department of Justice to act as the consumer's lawyer in Federal agency procedings and in the courts.

The Consumer Protection Act contained provisions to expand the jurisdiction and powers of the Federal Trade Commission. Of material benefit to the elderly, since they are frequently the special targets of the unscrupulous, would have been the prohibition by the bill of 11 specified types of consumer fraud and deception which constitute the vast bulk of fraud and deception. The bill further created a private right for consumers—either singly or together as a class—to sue for relief after the determination of a successful Government action against practices prohibited by the bill. The right to a private remedy represented progress for many of the elderly who are among those who can least afford the loss, are least likely to know the legal procedures for recovery, are most hesitant to involve themselves with lawyers and the law, and are least able to pay the cost of litigation even if they know the procedure.

The Consumer Product Testing Act would have allowed the Federal Government to review standards for evaluation which are used by private testing laboratories and to publish its findings as to their adequacy. The Federal Government would have had the authority to develop standards if no other testing method or inadequate testing methods existed and could not be expeditiously developed by private sources.

The Drug Identification Act made possible the rapid identification of drugs and drug containers in a time of personal emergency.

The Consumer Warranty Act established Federal minimum standards for warranties, prohibited the disclaimer of implied warranties if the terms warranty or guaranty were used in connection with a sale, and encouraged mechanisms for informal settlement of warranty disputes.

Unfortunately, not one of the five administration bills was passed by the 91st Congress.

Legislation of 1970 signed into law by the President which aids the elderly consumer—and others as well—included the Fair Credit Reporting Act. Mrs. Knauer testified before Congress in support of this law. The law allows a consumer, upon proper request and identification, to know the nature and substance of all information about himself (except medical information) on file with a consumer credit bureau. The law also enables an individual to protect himself against the dissemination of inaccurate or incomplete information bearing on his credit worthiness, insurability, or employability.

Another new law of aid to the elderly consumer bans the issuance of unsolicited credit cards. No credit card may now be issued except in response to a request or application for the credit card. In addition, the law limits the liability of the cardholder for the unauthorized use of any credit card of his to $50.

During 1970 Mrs. Knauer testified in person on behalf of the Administration's legislative proposals and the following programs which are of benefit to the elderly: improvements in Federal packaging and labeling laws, care labeling of textile products, and retail food store advertising and marketing practices.

Many times over the past year Mrs. Knauer sent written comments to various Federal agencies and committees of Congress urging policies and programs to aid consumers, including the elderly. She urged improved meat inspection, better quality standards for household furniture, the continuation of the tax exemption which is an important means of support for public interest law firms who often act in behalf of consumers, and correction of abuses in the negative option which is a typical means of merchandising used by book and record clubs. Her position, if adopted, that medical practitioners should not share in the profits of drugs and medical devices which they prescribe could save the elderly appreciable amounts on medical expenses. She has made statements against a restrictive national foreign trade policy because it would add to the costs of many consumer goods and probably lessen consumer choices, especially choices of inexpensive goods. She also opposed most restrictions on charter flights—with the notable exception of restrictions necessary for air safety—in part because their low cost enables many of the elderly to travel who could not otherwise afford to fly.

PRODUCT INFORMATION

This past year saw a great aid to the aged as well as to all other consumers in the form of Executive Order 11566 on consumer product information. The President, in his consumer message of October 1969, directed Mrs. Knauer, his Special Assistant for Consumer Affairs, to develop a program for disseminating consumer product information which the Government accumulates in the process of purchasing consumer items for its own use and to carry on further studies as to how the skill and knowledge of Government purchasers could be shared with

the public in a fair and useful manner. To these ends, Mrs. Knauer convened an interagency committee from 22 agencies which developed a report upon which the Executive order was based. The information to be released will provide older consumers who are on limited incomes with more purchasing power for their dollar, primarily by identifying the qualities they should look for when buying consumer products. This information will be translated from its current technical form into a form usable by individuals.

The Executive order empowers the President's Committee on Consumer Interests to provide continuing policy guidance and overview functions in connection with the dissemination of product information provided for by the order.

In addition, the Executive order calls upon the President's Committee on Consumer Interests to make the public more aware of the materials which are already available from the Government. These materials will also prove to be of benefit to the aged.

CONSUMER EDUCATION AND INFORMATION

Distribution of materials useful to the elderly continued regularly throughout the year to individuals themselves, institutions, community organizations, and other groups concerned with the elderly. These materials contained information on such topics as consumer fraud, truth in lending, housing, food, drugs, and automobiles. The distributions included the President's Committee's "Consumer Education Bibliography" (widely used by organizatons to prepare programs and reading lists for their members); "Consumer Information," published by the U.S. Government Printing Office containing a special section of consumer references in large type especially for the senior citizen; various pamphlets for the elderly prepared by the Federal Trade Commission, the Administration on Aging and the U.S. Department of Agriculture (including "Food for the Elderly"); and the President's Committee's series of pamphlets prepared especially for use by people, including the elderly, with limited incomes.

The speak up series, brochures with bright colors, large type, and helpful illustration, have been developed this year to aid consumers in preventing some of the most common types of consumer fraud. The pamphlets currently available cover the areas of contracts, door-to-door sales, and buying an automobile. A total of 10 brochures are anticipated in the series.

The President's Committee on Consumer Interests has developed definite plans for adult consumer education guidelines with emphasis on special socio-economic groups and the elderly. The guidelines will be designed in such a way as to help local organizations establish continuing and adult education programs.

Mrs. Knauer's Public Affairs Office has provided press releases and other materials to be used to advise consumers, the elderly included, on several topics such as: How to reduce fuel bills during the winter and how to protect home appliances from damage in case of a power blackout.

The Public Affairs Office has begun a communications program aimed at reaching the low-income consumer who often has severe consumer problems. Radio scripts have been created from case histories of victimized consumers in low-income brackets. A typical consumer problem is dealt with and a solution to it is given. The scripts and the case histories were sent throughout the United States to radio stations and newspapers, most importantly Spanish-language and Black-community ones. The program for developing scripts and case histories has been instituted on a continuing basis. The mass media programs should be of great importance in reaching those elderly who, because of illness or financial straits, are confined to their homes and who therefore do not have many contacts with the outside world other than the mass media.

Miss Elizabeth Hanford, Executive Director of the President's Committee, appeared in a 30-minute television program, "Consumer Problems in the Retirement Years." The program is part of a series of the American Association for Retired Persons called "Golden Years; A Time for Retirement." It will ultimately be aired on 100 television stations across the country.

During the past year, the President's Committee provided the editor of a magazine for senior citizens with guidance and assistance on the best ways to transmit consumer information to the elderly.

DIRECT AID TO THE ELDERLY

In addition to information which Mrs. Knauer supplied directly to the elderly on request, 1970 saw the continuation and growth of the practice of referring many complaints to the manufacturer or retailer concerned and requesting that a speedy and fair resolution be worked out directly with the consumer.

All consumer letters—whether or not they were referred to a manufacturer, retailer, or Government agency of special expertise or jurisdiction—received individual replies from the President's Committee on Consumer Interests directed at resolution of the problem at hand. The files of Mrs. Knauer's Office of Consumer Correspondence indicate that most of the complaints from elderly consumers are in the following major areas of concern: Clothing (cost, quality, and style), drugs (cost), food (cost, diet foods, packaging, and labeling), funeral services, hearing aids, home repairs, insurance, mail orders, medical devices, mobile homes and social security. The largest number of complaints from the elderly in 1970 were about drugs, hearing aids, and mobile homes.

At speeches and various meetings throughout the year the occasion arose for Mrs. Knauer and many members of her staff to discuss consumer problems directly with the elderly who were in attendance. One such important meeting was the Consumer Workshop of the Institute of Lifetime Learning. A number of staff members also spoke at meetings of the American Association for Retired Persons and National Retired Teachers Association.

INDUSTRIAL RELATIONS

In 1970 Mrs. Knauer's procedures for working with industry groups were expanded to include formal liaison with over 200 industry trade associations who have accepted Mrs. Knauer's challenge to work with her and individual companies in bringing about equitable solutions to problems confronting the consumer. The benefits derived from this liaison will certainly be beneficial to the aged and to all other consumers. For example, in working with food chains, Mrs. Knauer has been instrumental in bringing about a favorable attitude on the part of the chains toward the adoption of voluntary unit pricing—a system of pricing per pound, per ounce, per pint, etc. (in addition to total price) which makes price comparison a simple matter and enables the elderly to get the most for their money in supermarket shopping.

Mrs. Knauer also obtained agreements from manufacturers of consumer durables supporting simplication and improvements of warranties covering durable items purchased by the elderly.

Just as in the earlier case of the standard for fat in hot dogs, Mrs. Knauer vigorously argued for tight limitations on the fat content in hamburgers, a food item frequently purchased by the elderly consumers.

LIAISON WITH GOVERNMENT AND PRIVATE ORGANIZATIONS REPRESENTING THE AGING

During 1970 Mrs. Knauer maintained continuing liaison with Mr. John B. Martin, U.S. Commissioner on Aging, Administration on Aging. She has been working closely with him in planning the 1971 White House Conference on Aging. The President's Committee on Consumer Interests has been engaged in the formulation of Conference topics which will include housing, nutrition, health, education, transportation, and delivery of consumer services to older people. The Consumer Advisory Council, a group of experts from private and public life who were appointed by the President to advise him and the President's Committee on Consumer Interests, has also been engaged in the planning areas of the White House Conference.

In 1970 the President appointed a widely-respected expert on problems of the aging to the Consumer Advisory Council. The appointee is Dr. Wilma Donahue, recently retired Co-Director of the Institute of Gerontology, University of Michigan; Consultant to the Administration on Aging; and Chairman of the Michigan Commission on Aging.

The President's Committee on Consumer Interests has continued its work with the Department of Housing and Urban Development, particularly under Project Breakthrough, to increase the availability of housing at all income levels, particularly for the low- and moderate-income consumers, many of whom are elderly.

During 1970 the President's Committee on Consumer Interests maintained contacts with national organizations with special emphasis on the aging such as the American Association for Retired Persons, National Retired Teachers Association, and National Council of Senior Citizens. The President's Committee encouraged them to develop further their programs to inform and educate the aging consumer as to problems he might face, resources at his disposal for assistance on local, State, and national levels, and information sources.

In June of 1970, the National Retired Teachers Association honored Mrs. Knauer with a citation for her significant and valued contributions to the enrichment of retirement living.

Of special note, the President's Committee maintained regular liaison with an Ad Hoc Advisory Committee on Consumer Interests as a means of coordinating consumer activities of some thirty-six national voluntary organizations. In October 1970 the Ad Hoc Committee adopted a statement emphasizing the crisis in the Nation's health care system, specifically noted the "tragedy of nursing home care in this country," and included among its recommendations that available standards under the Social Security Act be better enforced and that existing HUD and HEW nursing home programs be more fully used and coordinated.

FEDERAL-STATE RELATIONS

The establishment of a Division of Federal-State Relations in the President's Committee on Consumer Interests in June 1970 should have long-range benefits for the aging, both directly and indirectly.

The division is responsible for liaison with States and local subdivisions in order to promote cooperation and communication on consumer affairs between the Federal Government, the States and local subdivisions. It will encourage, cooperate with, and assist the States and local subdivisions in the establishment and strengthening of consumer protection offices, effective laws, and programs. It will provide consultative and technical assistance in the development and drafting of effective State and local consumer protection laws.

The office will have responsibility for identifying consumer problems and unmet needs common to the States which may require Federal action, Federal-State cooperation, or cooperative State action.

The preliminary work has been completed for a comprehensive study of State consumer protection laws.

The President's Committee on Consumer Interests will continue to be concerned with the consumer problems of the elderly as it undertakes work specifically oriented toward the aged and as it works in support of consumer programs to benefit all Americans.

ITEM 16: VETERANS' ADMINISTRATION

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., December 30, 1970.

DEAR MR. CHAIRMAN: In response to your request of November 25, 1970, it is a pleasure to forward the enclosed report on Veterans' Administration activities relating to aging for the year 1970.

As I have indicated previously, the VA is very much concerned in the problems of older people since so many of our veterans are in or approaching that period in life. The effort by your committee in seeking ways to help older Americans is highly commendable.

I hope the enclosed report will be useful to your committee.

Sincerely,

DONALD E. JOHNSON,
Administrator.

[Enclosure]

VA ACTIVITIES AFFECTING OLDER VETERANS IN 1970

DEPARTMENT OF MEDICINE AND SURGERY

1. VA hospitalization

As of October 15, 1969, there were 22,269 patients 65 years and older remaining in VA hospitals. They represented 25.4 percent of all patients in VA hospitals on that date. Within that group, 11,349 were 75 or older, an increase of 1,694 from the previous year. During calendar year 1969, 21.6 percent of all discharges from VA hospitals were represented by the 65-and-older group.

Characteristically, older individuals tend to be afflicted with chronic diseases, and often one patient will be found to be suffering from several chronic ailments simultaneously. As a result, older veterans constitute a sizable percentage of the population of all VA long-term and chronic care facilities. To meet special needs of the aging and elderly veteran who is also disabled by chronic illness, it has been necessary to develop special programs or to modify existing ones.

2. Extended care service

a. Inpatients.—Within the Department of Medicine and Surgery, the Extended Care Service has developed and operates a system of facilities to care for the total spectrum of patient-care needs that are included within the concept of long-term care. While these facilities serve all veteran patients requiring such care, they are of particular importance for those who are 65 and over, who make up over one-half of the long-term group.

Specifically, the Extended Care Service includes services in:

(1) Intermediate care, which provides hospital treatment for those who are chronically ill but still require physician's care and supervision on a more or less daily basis.

(2) Nursing home care, for those who no longer require close medical supervision, but whose disabilities are such that they require skilled nursing care.

(3) Domiciliary care, for veterans who are disabled by chronic medical or psychiatric disease, but are nevertheless capable of performing the activities of daily living.

(4) Restoration programs, for those who may be expected to return to community living after a period of rehabilitation.

(5) Hospital-based home care, for those who are bedridden but can be cared for at home with professional support by the hospital staff.

In fiscal year 1970, Extended Care Service operated approximately 1,700 intermediate care beds, 4,000 nursing care beds, approximately 13,000 domiciliary beds and 759 restoration beds.

Paralleling the above programs are a number of veterans programs operated by the several States with particular emphasis on the aged. For example, in fiscal year 1970, State facilities had an average veteran census of 5,903 in domiciliaries, 2,432 in nursing home care units, and 418 in hospitals. During the same period, community nursing homes provided care for an average of 3,581 per day under contracts with the VA.

The aim of the extended care service, throughout all these facilities, is to attempt to prevent further deterioration by encouraging the patient to make maximum use of his remaining facilities. By providing a spectrum of care, it is possible to provide care for a patient at the lowest level of institutional care consistent with his total needs, and thus neither overtreat nor undertreat.

b. Outpatients.—In fiscal year 1970, patients in the age group 65 and over made over 915,000 visits to staff and fee-basis physicians for outpatient treatment, representing about 13 percent of the total outpatient treatment load. The aging veteran thus continued to represent a significant percentage of the outpatient load, just as they did the inpatient load.

3. Medical service

Delivery of excellent health care to the aging presents a continuing challenge to medical service. Not only does the older individual's health problems require highly complex diagnostic procedures, but he is likely to be afflicted with multiple illnesses. Even after a diagnosis is made, treatment of an illness is often difficult since the older person does not tolerate many of the modern forms of therapy very well. Complicating treatment further are the many psychosocial problems which accompany the frequent prolonged and complicated illnesses in the group.

At all levels of care, VA medical services are making major efforts to restore the elderly patient to full activity as quickly as possible, thereby reducing his dependency on a hospital environment. To expedite this process in the patient recovering from his illness, we are establishing "intermediate care sections" where convalescent patients are guided and encouraged to become independent and active. There are currently 1,600 beds under the direction of medical services which are designated as specializing in "intermediate care," and it is expected that we will increase the number of these beds very significantly in the next few years.

Planning for comprehensive care for eligible veterans requires that medical service project a significant increase in its treatment of patients in an ambulatory setting. This will be of benefit to the elderly veteran, since allowing him to be treated as an outpatient will further encourage his self-sufficiency and may thereby contribute significantly to his complete recovery.

Finally, medical service personnel are actively engaged in research and teaching activities directed toward improving the health of the aging individual. The

research projects cover a wide range of basic and clinical studies. Teaching programs are conducted in aspects of geriatric medicine for medical students, interns, residents, and allied health workers. The fact that half of our hospital's medical services are closely affiliated with medical schools will guarantee that these efforts in patient care, research and teaching will have a major impact on health care delivery for the aging veteran.

4. Physical medicine and rehabilitation service

This service is primarily a supportive service to all of the other patient treatment services in our hospitals and outpatient clinics. As such it treats a large number of patients of all types in age groups from 18 to 80 and older.

In the face of modern drugs and medical technology, life span has been lengthened quite dramatically during the past several decades. The direct effect of this has seen our workload increase by ever growing numbers of long-term (chronic) aging patients.

Illnesses and disabilities common to the aging are for the most part degenerative processes. With good medical care and rehabilitation medicine a great deal of temporary improvement is possible, so that many patients may again take an active part in society as productive wage earning citizens. Should such a goal not be attainable, however, P.M. & R. Service strives to bring these individuals the opportunity to live at the maximum mental and physical level attainable within the hospital community.

Because of the very nature of its component therapies, the Physical Medicine and Rehabilitation Service is in the most strategic position to provide a program of maintenance therapy to prevent the rapid deterioration of patients and members whose age or medical condition pose problems of self maintenance. Maintenance therapy is a program of minimal activity designed to maintain at the maximum feasible level the physical and mental condition of patients or members who have arrived at a stage where greatest benefit has been received from normal intensive medical treatment and there is poor prognosis for improvement. The objectives of the program are:

(*a*) Continue self-help ability as long as possible.

(*b*) Delay the necessity for maximum nursing care.

(*c*) Improve morale of geriatric and chronic, long-term patients and members.

(*d*) Fill a need for sustaining therapy by the development of specialized larger group techniques.

(*e*) Screen geriatric, chronic long-term patients and members to determine those with the will and capacity to improve under more individualized therapy.

5. Social work service

It is the aim of Social Work Service to help each older person in the VA Health Care System live with dignity and self-respect, utilizing his residual abilities to the fullest extent possible and developing unrealized potentials. Every effort is made to prevent the development of a sick, dependent role which can result from long-term hospitalization and to encourage a healthier, more self-sufficient role in a family and a community. Frequently this means helping to create a place for the veteran within his own family group or developing a homelike situation in the community within which he can function. This year, Social Work Service participated with the Extended Care Service in developing a hospital-based-home care program which has particular relevance for the older person. Under this program the whole range of health care and services can be provided in the patient's own home where he may be more comfortable and content. For others, continued care in an institution is necessary and the VA offers long-term nursing care in VA hospitals and private nursing homes. Some ambulatory patients able to care for themselves are transferred to VA residential centers where many rehabilitation services are available to assist in the restorative process. Others without families are assisted in finding a congenial foster home where they can enjoy the full benefits of private family life. Social workers offer ongoing supportive service to patients, families, foster families, and institutional personnel to assist them in establishing and maintaining the kind of positive, mutually dependent relationship which will sustain them and help them achieve social satisfactions and personal integrity.

To supplement their direct services to patients and their families in the community VA social workers develop and supervise activities of volunteers who provide social and recreational outlets for older patients with restricted mobility. Social workers also participate with other private and public health organizations on both a local and national level in identifying the needs of older persons

and developing programs to meet their needs. For example, of particular concern has been the need to develop and train home health aides to provide medical support services in the home.

6. Psychology service

Increasing numbers of elderly veterans with chronic diseases and disabilities in VA hospitals, nursing home care programs, and increasing professional involvement in the domiciliary program attest to the concern for the care and treatment of this significant group in the veteran population. Many of the diseases and disabilities associated with advancing age manifest themselves in psychological deficits, especially in the areas of emotional and intellectual functioning. In many instances the particular medical condition is accompanied and aggravated by psychological inadequacies. Often it is the psychological deficit which is being attacked when medical intervention is introduced. Both the medical and psychological practitioner are in need of better quantitative measures to evaluate psychological deficits and changes taking place in order to guide appropriate care, treatment and rehabilitation of aging veterans. Psychologists in the VA, therefore, are intensifying efforts to broaden application of their clinical treatment and rehabilitative programs based upon past research findings and continued study.

To augment this approach the Psychology Laboratory for Research in Aging moved recently to the VA Center, Bay Pines, Fla., to maximize the opportunity for it to be an integral part of the Center's total effort in the delivery of services, education, training, and research related to older veterans. A high concentration of older patients and members from this VA center make it an ideal situation for collaboration between the clinical and research staff. The presence of all aspects of extended care facilities at this center enhances these efforts.

While new knowledge is being sought and new program efforts are developed and evaluated in this kind of research-clinical environment, psychologists continue to increase their direct participation in hospitals and domiciliaries across the country. Assistance is given to nursing home supervision in establishment of psychologically harmonious environments in VA nursing home units. In much the same way that a crutch supports a weakened limb, certain psychological prosthetic elements can be built into the living environments of the elderly to help them maintain their spatial and temporal orientations so that confusion, memory loss and anxiety are reduced.

Principles derived from research on the learning process are being applied to assist aging veteran patients. Classlike sessions help them to learn and retain such things as the date, names of patients, and staff personnel with whom they associate, and other orienting facts. Such techniques have significantly reduced the development of confusion in many elderly patients and have helped aged veterans to strengthen and utilize again faculties which had been impaired. Reinforcement therapy techniques instituted by phychologists, are assisting in the development of appropriate behaviors needed to allow the psychiatrically aged patients to maintain themselves in noninstitutional settings. Such things as neatness, eating habits, and control of body functions are especially helped by these treatment techniques.

In numerous hospitals psychologists are working with the elderly veteran on specific conditions which are amenable to assistance by psychological means. For instance, in one hospital patients suffering from strokes meet with the psychologists in a group therapy support session with focus placed upon adjustment of these patients to their more restricted mode of living. At other VA installations the psychologist works with elderly patients who suffer from emphysema with specific focus being placed on establishing behavior patterns which assist them in their therapeutic program such as establishing breathing exercises and patterns. As treatment progresses the patients are helped through applied psychological principles to discard behaviors such as smoking which are detrimental to their treatment and rehabilitation regimens.

In summary, psychology is deeply interested in, and substantially contributes to, the research, treatment, rehabilitation and social and vocational restoration of our senior veteran patients.

7. Dietetic service

Adequate nutrition is essential to the well being of the aged. Many of the mild disabilities so frequently accepted as part of growing old may in fact be due to insufficient amounts of essential nutrients in the diet. In addition, there is increasing evidence that an overabundance of calories accelerates the on-

set of such diseases as atherosclerosis and diabetes. Studies of the elderly conducted by dietitians in VA indicate that these patients usually eat smaller quantities of food, require some modification of the diet in nutrients as well as consistency, and that a large number require assistance in feeding. Some must be spoonfed their entire meal and almost all need assistance in opening milk cartons, buttering bread, pouring coffee, etc. Use of prosthetic devices is encouraged by the dietitian as they are helpful to patients who have difficulty feeding themselves. Whenever possible the older patients, whether ambulatory or in wheelchairs, eat in a dining room or dining recreation room area. Eating with a group, rather than receiving a tray at the bedside, usually indicates progress to the patient and boosts his morale.

It is important that all dietetic staff be kept informed about current trends in nutrition and changes in treatment for the elderly as well as the nursing home care patient. A sound knowledge of the nutritional care required by the aged fosters an increasing interest and enthusiasm in treating this growing segment of the veteran population.

8. Voluntary service

Because they have the time, an understanding of human needs, and a maturity of experience, retired and older persons made an even greater contribution to the care and treatment of veteran patients during the past year.

Older volunteers, through staff supervision, found new ways to help the veteran both in the hospital and the veteran under VA's care away from the hospital. In no way did older volunteers take the place of paid staff either in the hospital or the community.

Because of their experience and maturity, these volunteers were of invaluable assistance in areas of service to patients. Through the guidance of older volunteers, veterans were given the incentive to learn to talk again, to share mutual interests, to understand more about their physical conditions, and how to manage to live their lives within their limitations and under the best possible conditions.

The older volunteer who did not live near a VA hospital found more and more opportunities to help former hospitalized VA patients adjust to their new surroundings in community nursing homes or in community care programs in which volunteers serve. These older volunteers helped veterans build confidence in themselves and once again become useful and productive citizens.

But concomitant with the service received by the veterans was an equal if not greater satisfaction and pride given the volunteer. For it was in doing something for someone else that the older or retired volunteer found he was needed and again a part of the mainstream of life.

9. The research program on aging

The VA sponsors basic and clinical research programs on a broad front to meet its responsibilities to our increasing number of aging citizens and older patients. Emphasis is placed on accumulated evidence that aging is a biological process with gradual loss of function as a result of unknown mechanisms; that there is an indistinguishable boundary between biologic processes that produce certain kinds of disease and phenomena that cause aging. A survey showed that the prevalence of 11 chronic conditions is significantly greater among older individuals. These 11 conditions are: Arthritis and rheumatism, asthma, hay fever, heart conditions, hearing impairments, peptic ulcer, high blood pressure, hernia, visual impairments, diabetes, chronic bronchitis, and paralysis. Basic and clinical research programs, with emphasis on the changes that occur with age, include investigations in the mechanisms of aging from the standpoint of current concepts in biology, heredity, biochemistry, disease processes, and the environment. A few examples of aging research sponsored by the VA follow.

At the Boston VA outpatient clinic a normative aging study is in progress with a study population of 2,000 male veterans rigidly screened for an initial high level of health and with a reasonable assurance of geographic stability to assure their lifetime participation. Each subject will be followed periodically over the course of his lifetime to learn what changes occur at what point in time and under what circumstances. The longitudinal design of this study will delineate true age changes since such studies determine what actually does happen as well as when and how it happens.

Based on a pilot study, planned in collaboration with the Armed Forces Insitute of Pathology, a cooperative study is in progress on the endocrinological aspects of aging in men. This is a study of endocrine glands obtained at

autopsy. The primary purpose is to observe the structural characteristics, both gross and microscopic, of the endocrine glands and their target organs at various adult male ages and within various disease categories; to evaluate and provide a description of the frequency of these characteristics in the various age groups and disease groups. The secondary purpose is to attempt to detect any trends or relationships in the structural data collected which might appear to reflect aging per se; trends which could be made the basis for future separate studies each designed to test some specific hypothesis. Dr. Thomas H. Capers of the Dallas VA hospital is the principal investigator.

Characteristic biochemical and histochemical changes in connective tissue related to aging are studied in the laboratory at the VA center, Jefferson Barracks, Mo. Changes in elastic fibers are responsible for loss of resiliency and for the accompanying dilation of blood vessels. Under this project the aging factors in human tissues are investigated by histochemical, electron microscopic, and biochemical techniques. It was shown, from the data of amino acid composition of aging arteries, that the characteristic change in aging of elastic fibers is in the primary structure of the protein. This observation is important since it indicates a genetic basis for the redifferentiation of elastins for the young to the arteriosclerotic type after maturity of the smooth muscle cells of arota.

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.

The Biochemistry of Aging Research Laboratory at Bedford VA hospital headed by Prof. Marott Sines is concerned with changes in RNA and DNA. the substances that are the basis for inheritance. The work here is concerned with investigating a theory of aging that it is a process programed at birth by the genes inherited from our ancestors. It is an effort intensively focused on the molecular mechanisms of aging, an understanding of which would help greatly a variety of other types of studies on the nature and causes of the aging processes. For example, the relation of age to protein synthesis and enzyme activities is under investigation by Dr. Kuang-Mei H. Wang at the Buffalo VA hospital. This investigation examines possible correlations between the development of enzymatic activities and the appearance of certain function in these organs. The changes in enzymatic activities may indicate increase or decrease of protein synthesis. Studies of protein synthesis in embryonic organs involving activation of amino acids and transfer of the amino acids into ribosomes by soluble RNA for the final assembly of polypeptides would help to explain the changes in enzymatic patterns relating to 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. He is pursuing these studies by examining the response of several inducible enzymes to administration of hydrocortisone, a secretion of the adrenal gland, in an attempt to separate tissue building and tissue breakdown components which theoretically plays a role in growth and in aging.

Some other typical investigations in aging that are conducted throughout the VA system are: At the VA Hospital at Birmingham, Ala., investigators are studying effects of aging and hormones on protein synthesis; at the VA Center, Bay Pines, Fla., and at VAH, Sepulveda, Calif., researchers are exploring age-related differences in mechanisms of memory and learning and seeking to identify the sources of these differences. At the VA Hospital, Pittsburgh, Pa. (Leech Farm Road), investigators are examining the relationship of biological membranes to the aging process and at the VA Hospital, Jackson, Miss., research is also being conducted on the effects of aging on organs and tissue blood flow. At Downey VA Hospital a research group is studying the lens of the eye, susceptible to aging rather early in life and more readily accessible than many body tissues, as a model for the aging mechanism.

Understanding the nature and causes of aging is the goal of the clinical and basic sciences studies which are fostered by the VA Research Service. These investigations are part of a broadening effort of increasing our biological knowledge of aging processes with the purpose in view that this will generate an improved basis for medical care and therapy of the aged.

DEPARTMENT OF VETERANS BENEFITS

1. Guardianship program

As it affects aging incompetent VA beneficiaries, guarandianship program activities are twofold. Initially, a personal contact is made with the beneficiary to assess his situation and determine the type of fiduciary most suitable. Under Federal statute, payments in a fiduciary capacity may be made to a legal custodian, the chief officer of an institution, or the wife of a veteran. The appointment of a guardian is avoided unless payment cannot be made by any other means which wou'd be consistent with the best interests of the beneficiary. A guardianship is costly and reduces the amount available for the beneficiary's care, and it still carries with it the stigma of incompetency associated with a judicial decree appointing a fiduciary.

Once a fiduciary relationship has been established, continuing supervision is maintained by calling and auditing accounts in certain cases and personal contacts with the beneficiary. Personal contacts are made to evaluate the beneficiary's welfare, performance of the fiduciary and fund usage. The frequency of personal contacts is tailored to the needs of each beneficiary in order to give necessary service within available resources. Field personnel maintain liaison with State and local agencies working with the aged to obtain any additional assistance available for such beneficiaries.

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 over 1,750,000 persons age 65 and older. This total is broken down to 921,070 veterans, 633,386 widows, 145,088 mothers, and 52,280 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. Approximately 500 persons over 65 years of age are enrolled in the education program under chapter 35 of title 38, United States Code.

Appendix 2

INFORMATION ABOUT THE PRESIDENT'S TASK FORCE ON AGING

ITEM 1: STATEMENT BY PRESIDENT RICHARD M. NIXON, OCTOBER 10, 1969

THE WHITE HOUSE

The President today announced another in the present series of task forces that are being established to assist the Administration with ideas and recommendations for 1970 and beyond. Garson Meyer, President Emeritus of the National Council on Aging and Chairman of the Advisory Committee of the New York State Office for the Aging, will be the Chairman of the Task Force on Problems of the Aging. The task force will examine the problems faced by older people in order to determine how they can best achieve security, dignity and independence. It will review existing programs, suggest improvements in them, and recommend further actions that might be taken in this important area.

The members of the Task Force on Problems of the Aging are:

GARSON MEYER, *Chairman*
Chairman, Advisory Committee
New York State Office for the Aging
Rochester, New York

BERTHA S. ADKINS
Former Under Secretary of HEW
Oxford, Maryland

WALTER M. BEATTIE, JR.
Dean, School of Social Work
Syracuse University
Syracuse, New York

COLIN D. CAMPBELL
Professor of Economics
Dartmouth College
Hanover, New Hampshire

MARGUERITE STITT CHURCH
Former Member of Congress
Evanston, Illinois

LYMAN C. HUNT, SR.
Member, Legislative Council
National Retired Teachers Assn., and American Assn. of Retired Persons
Essex Junction, Vermont

INABEL B. LINDSAY
Former Dean, School of Social Work
Howard University
Washington, D.C.

EDWARD G. LINDSEY
Director of Health Services
State Communities Aid Association of New York
New York, New York

WOODROW MORRIS
Director, Institute of Gerontology
University of Iowa
Iowa City, Iowa

ROGER F. MURRAY
Executive Vice President
Teachers' Insurance and Annuity Association and College Retirement Equities Fund
New York, New York

OLLIE A. RANDALL
Member of the Board
National Council on the Aging
New York, New York

Mrs. A. M. G. (BONNY) RUSSELL
Chairman, California Commission on Aging
Sacramento, California

WILBUR H. STRICKLAND
Former Chief of Endocrine and Metabolic Clinic
Mercy Douglas Hospital
Philadelphia, Pennsylvania

PRESCOTT W. THOMPSON
Psychiatrist
Former Director
Retirement and Aging Study Program
Menninger Clinic
San Jose, California

ITEM 2: INTRODUCTION TO TASK FORCE REPORT, "TOWARD A BRIGHTER FUTURE FOR THE ELDERLY, APRIL 1970", AND A SUMMARY OF RECOMMENDATIONS

INTRODUCTION

Some Americans accept the elderly and respect them; some Americans fear the implications of aging and, therefore, shun the elderly; most Americans are indifferent to the elderly. They forget that life continues after the age of 65, that life's posibilities remain, that some of life's concerns intensify. In a production-oriented society excuses abound for neglecting the elderly; measures for enriching the later years or to compensate for the vulnerability of the aged are accorded a low priority, are delayed, are enacted on too small a scale, or are not proposed at all.

The Task Force is convinced that there must be greater awareness of both the presence and the potential of all older persons within our society. Recognizing their presence requires concern for and attention to their special circumstances. Recognizing their potential requires the rest of society to stop viewing the elderly *only* as a problem.

In examining the needs of the elderly, the Task Force has concluded that the Nation's 20 million citizens over 65 are so diverse a group that no generalization can fully describe them. The Task Force believes that it is fair to say, however, that too frequently old age in this country is characterized by the almost total absence of choices. In essence the Task Force is recommending a program to expand the range of choices open to older persons in the belief that human beings should be able to live with purpose and dignity throughout their entire life span. In the American scheme, purpose and dignity should include the possibility of choices.

To meet the needs of older persons more adequately, and to give the elderly a greater opportunity to contribute to society, the Task Force believes that government should act with and on behalf of the elderly much more vigorously than it currently does. At the same time, the Task Force recognizes that government action alone is not enough. More of the energies of voluntary organizations, of volunteers, of unions, and of business must also be devoted to this undertaking. Thus, fulfillment of many of the recommendations of this Report will require new partnerships between government and the private and voluntary sectors.

For millions of the Nation's older persons, the quality of life in the later years depends upon action being taken now, both in order to benefit those who are now elderly, as well as the 1.4 million persons who annually reach age 65. Immediate action is justified by the contributions of the elderly to the national economy. The Nation must not lose sight of the efforts that those now old have made, and can, if given the opportunity, continue to make, to build our great productive capacity.

The Task Force also believes that another and quite different case can be formulated for immediate action. People do not suddenly become old when they reach the age of 65, nor do they start preparing on that date for their later years. The high school student earning social security credits while he works as a supermarket bagger; the young business executive who gives up smoking; the housewife who returns to school after raising her children; the union member who votes to increase his contribution to the union pension fund; the couple in their early 50's using up their savings to put two children through college and to help meet the costs of lengthy and expensive nursing home care for an 85-year-old parent—each is doing something which will have an important bearing on his own old age.

This country is not granting a special privilege to the elderly in removing barriers to fuller participation in American life. It is sharing the fruits of a future they helped create with citizens who have worked hard to insure for themselves an old age of dignity, security, and independence.

The Task Force has labored hard to produce a program which the Nation can attain if it but chooses to do so. Where the Task Force calls for new or expanded public programs, it does so in the belief that the action is essential to the well-being of substantial numbers of older persons.

A brief word is in order about the image of older persons as conveyed by this Report. Although it is aimed at the needs of all the elderly, it places particular emphasis on those who, to varying degrees, require the special concern of society. To say that an older person needs more help is not to say

that all elderly require more assistance or that the older person who does is feeble, useless, or completely dependent. In concentrating on the difficulties which some persons experience in old age, the Task Force did not lose sight of the great number of elderly who possess enormous inner resources and who are every day making important contributions to their communities.

President Nixon, in his 1968 Presidential campaign, declared, "A just and decent society must recognize its debt to its older citizens and honor its obligations to them."[1] His Presidential Task Force on the Aging concurs. It commends the ideas that follow to the President of the United States in the knowledge that he shares with it the understanding that what government does makes a difference.

Summary of Recommendations

The Report of the Presidential Task Force on the Aging contains 24 recommendations. The Task Force realizes that all of them cannot be effected at once. It does hope, however, that each will be given careful consideration as basic elements in the national provision for living in the later years.

In the body of the report each recommendation is accompanied by a discussion which reflects the rationale underlying it. In this summary the recommendations are listed in two ways. First, they appear in the order in which they occur in the Report. Second, the recommendations are ranked in the order of importance which the Task Force has assigned to them.

The 24 recommendations, in the order in which they are discussed in the Report, are as follows:

Recommendation 1

Establishment of Executive Office on Aging

We recommend that the President establish an Office on Aging within the Executive Office of the President. We recommend that the President seek statutory authority for this Office through an amendment to the Older Americans Act but that until such authority can be obtained the President create the Office by issuing an Executive Order.

We recommend that the responsibilities of this Office include: (1) the development of national policy on aging; (2) the overseeing of planning and evaluation of all Federal activities related to aging; (3) the coordination of such activities; (4) the recommendation of priorities to the President; and (5) the encouragement of Federal agencies to undertake research and manpower preparation. We recommend that in addition the Office advise the President on concerns of the aging and alert other government officials to the potential impact of their decisions on the interests of older persons. In our judgment these responsibilities warrant Cabinet level status for this Office.

Recommendation 2

Emphasis on Aging in Six Human Resources Agencies

We recommend that the heads of the human resources agencies—the Departments of Health, Education, and Welware; Housing and Urban Development; Labor; Transportation; and Agriculture; and the Office of Economic Opportunity—develop organizational mechanisms capable of: 1) interrelating each of the programs of their agencies which affect the elderly; 2) assuring that planning undertaken by their agencies does not neglect the elderly; and 3) calling the needs of the elderly to the attention of key decision-makers.

Recommendation 3

Appropriation for White House Conference on Aging

We recommend that the President request, and Congress appropriate at the earliest possible date, the full amount of the authorization for the 1971 White House Conference on Aging.

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[1] Richard M. Nixon "A Statement on the Problems of the Aging—September 29, 1968."

RECOMMENDATION 4

Establishment of Pension Commission

We recommend that an independent Pension Commission be established and that it be authorized to engage in activities which result in protection of employee rights in the fullest sense. We further recommend that operations of this Commission be financed through fees paid by plans for services rendered by the Commission.[1]

RECOMMENDATION 5

Design of Portable Voluntary Pension System

We recommend that the President direct the Pension Commission, as a high priority, to enlist the ingenuity of the financial community in designing as a companion to the Social Security system a portable voluntary pension system.

RECOMMENDATION 6

Abolition of Work Income Test

We recommend that the work income test under Old Age and Survivors Insurance be abolished for those aged 62–72.[2]

RECOMMENDATION 7

Computation of OASDI Benefits Based on Combined Husband-Wife Earnings

We recommend that the earnings records of a husband and wife be combined to compute a single primary benefit from which the family's benefits will be determined, when such a combination results in larger benefits being payable.

RECOMMENDATION 8

Bringing All Elderly Up to the Poverty Line

We recommend that the President revise the proposed Family Assistance Act so that all older persons are eligible for sufficient assistance to bring their total incomes up to the amount defined by the Federal Government as the "poverty line" for the elderly. We further recommend that the Federal Government bear 100% of the costs of such assistance.[3]

RECOMMENDATION 9

Use of Social Security District Offices for Family Assistance Act Eligibility Determination and Payments to the Elderly

We recommend that the President revise the proposed Family Assistance Act so that eligibility for assistance to the elderly under the Act be determined, and that all payments to the elderly under the Act be made, through the Social Security District Offices.

RECOMMENDATION 10

Comprehensive Review of Income Needs of the Elderly

We recommend that the President request Congress to authorize the convening of a bi-partisan body broadly representative of the Nation's leadership to propose new or revised means of meeting the income needs of the elderly. We recommend that this group examine the extent to which present systems meet the actual needs of older persons and the degree to which the Nation's economic capacity can be utilized to meet those needs with a view toward effecting a new or revised economic security system for the elderly before the end of the decade. We further recommend that the membership of this group include older persons to whom the problems associated with low income are a reality.

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[1] Mrs. Church does not concur.
[2] Miss Adkins, Mr. Lindsey, and Dr. Murray do not concur.
[3] Mrs. Church does not concur with the last sentence of this recommendation.

RECOMMENDATION 11

Medicare Modifications

We recommend that Medicare be modified to provide: 1) coverage for extended care and home care without prior admission to an acute care hospital; 2) expanded coverage for home care; 3) coverage of out-of-hospital drugs at the earliest date addministratively feasible; 4) removal of the 100-day time limit on skilled nursing home care for those patients who continue to need such care; and 5) coverage for early diagnostic and other preventive measures.

RECOMMENDATION 12

Geriatric Services Through Neighborhood Health Centers

We recommend that the President seek Congressional authorization for front-end financing from the Medicare Trust Fund of a full range of geriatric health services including community health aides devoted exclusively to working with the elderly, transportation to and from health facilities, home care, and preventive techniques such as screening and health education. We further recommend that wherever possible these services be delivered through neighborhood health centers. We also recommend that the number of such centers be expanded through front-end financing from the Medicaid appropriation.

RECOMMENDATION 13

Elimination of Medicare Restrictions on Psychiatric Care

We recommend that the restrictions in Medicare coverage on outpatient psychiatric care be removed so that Medicare pays the same benefits for outpatient psychiatric treatment as it does for all other medical care. We further recommend that the 190-day life-time limitation under Medicare for in-patient treatment in a psychiatric hospital be removed.

RECOMMENDATION 14

Establishment of a Commission on Mental Health of the Elderly

We recommend that the President request Congress to authorize the appointment of a Commission on the Mental Health of the Elderly comprised of representatives from concerned Federal agencies, national organizations. Congress, and the judiciary, and private citizens to study, evaluate, and recommend a comprehensive set of policies for the Federal Government, the several States, and local communities to pursue in this vital area.

RECOMMENDATION 15

Program of Research Regarding Health Care for the Elderly

We recommend that the Health Services and Mental Health Administration establish within the National Center for Health Services Research and Development a Council for the study of the organization, planning, management, financing, and delivery of health care for the elderly. We further recommend that within a reasonable period of time this Council design, conduct, and report on large scale experiments concerning comprehensive coverage, incentives for comprehensive care which could be added to existing health programs, and the effect of removing or reducing the deductible and co-insurance features of Medicare.

RECOMMENDATION 16

Establishment of a Separate Identity for Federal Housing Programs for the Elderly

We recommend that the Department of Housing and Urban Development in administering Federal housing programs recognize the needs of the elderly for specialized housing arrangements by developing and using separate guidelines for the provision of such arrangements concerning design, funding, and operation.

RECOMMENDATION 17

Study of Transportation Needs of the Elderly

We recommend that the President direct the Departments of Transportation, Housing and Urban Development, and Health, Education, and Welfare, and the

Office of Economic Opportunity to undertake jointly an intensive time-limited study of all aspects of transportation as it affects the lives of the elderly. The study should include the design and construction or modification of necessary equipment, experiments, and demonstrations. We further recommend that this study culminate in the formulation of recommendations on how best to meet the transportation needs of the elderly, so that appropriate action can be undertaken at any early date, including the submission of a program to the Congress.

RECOMMENDATION 18

Information Delivery System Through Social Security District Offices

We recommend that in addition to other community information and referral services the Social Security Administration establish a system for delivering information through its District Offices to older persons and their families concerning the availability of benefits and services for the elderly. We recommend that the costs of the system be paid from general revenues. We further recommend that, wherever feasible, the Social Security Administration contract for performance of this funcion with voluntary organizations. Finally, we recommend that in the performance of this function older persons be employed or utilized as volunteers on a priority basis.

RECOMMENDATION 19

Consumer Education and Protection for the Elderly

We recommend that the proposed Office of Consumer Affairs, the Department of Health, Education, and Welfare, and the Office of Economic Opportunity mount an intensive campaign heavily emphasizing outreach techniques to offer consumer education and protection to the elderly.

RECOMMENDATION 20

Expanded Opportunities for the Elderly To Render Services

We recommend that the President issue an Executive Order directing all Federal agencies to cooperate with the Administration on Aging in identifying and designing opportunities for older persons to render services to their communities. We further recommend that the Older Americans Act be amended to authorize the Administration on Aging, after such opportunities are developed, to contract with appropriate Federal agencies for the rendering of service by older persons in local programs which those agencies support.

RECOMMENDATION 21

Education for Continued Living Throughout Life

We recommend that the Office of Education in cooperation with the Administration on Aging establish a new program to conduct research on, promote, and provide technical assistance to communities concerning education for continued living for life.

RECOMMENDATION 22

Multiple Senior Centers

We recommend that the Department of Housing and Urban Development, the Administration on Aging, the Office of Education, and the Office of Economic Opportunity undertake a joint Federal program in concert with local communities and groups to support the establishment and operation of multipurpose senior centers, including the development of Federal standards for such support, with the goal of ultimately making such facilities available to all older persons.

RECOMMENDATION 23

Nutrition Programs for the Elderly

We recommend that the President direct the Administration on Aging and the Department of Agriculture to develop a program of technical assistance and, when necessary, financial assistance, to local groups so that such groups can provide daily meals to ambulatory older persons in group settings and to shut-ins at home.

RECOMMENDATION 24

Additional Funding for Research and Training

We recommend that additional Federal funds be made available through Titles IV and V of the Older Americans Act, and appropriate research and training programs of the Public Health Service, and earmarked for investment in: 1) furtherance of curricula on aging in colleges and professional schools; 2) short-term training of professional, paraprofessional, and subprofessional personnel and of volunteers; 3) new career programs for the middle-aged and elderly; 4) basic and applied gerontological research; 5) research-training centers in aging; 6) dissemination of research findings; and 7) expansion of opportunities for graduate education in the field of aging. We further recommend that the manpower programs supported by the Department of Labor promote the development of personnel to serve the elderly.

The 24 recommendations, ranked in the order of importance which the Task Force has assigned to them, are as follows:

Establishment of Executive Office on Aging (Recommendation 1)
Bringing all Elderly up to the Poverty Line (Recommendation 8)
Emphasis on Aging in Six Human Resources Agencies (Recommendation 2)
Comprehensive Review of Income Needs of the Elderly (Recommendation 10)
Medicare Modifications (Recommendation 11)
Computation of OASDI Benefits Based on Combined Husband-Wife Earnings (Recommendation 7)
Elimination of Medicare Restrictions on Psychiatric Care (Recommendation 13)
Appropriation for White House Conference on Aging (Recommendation 3)
Design of Portable Voluntary Pension System (Recommendation 5)
Establishment of Pension Commission (Recommendation 4)
Geriatric Services Through Neighborhood Health Centers (Recommendation 12)
Abolition of Work Income Test (Recommendation 6)
Establishment of a Separate Identity for Federal Housing Programs for the Elderly (Recommendation 16)
Program of Research Regarding Health Care for the Elderly (Recommendation 15)
Establishment of a Commission on Mental Health of the Elderly (Recommendation 14)
Use of Social Security District Offices for Family Assistance Act Eligibility Determination and Payments to the Elderly (Recommendation 9)
Additional Funding for Research and Training (Recommendation 24)
Multipurpose Senior Centers (Recommendation 22)
Study of Transportation Needs of the Elderly (Recommendation 17)[4]
Expanded Opportunities for the Elderly to Render Services (Recommendation 20)[4]
Information Delivery System Through Social Security District Offices (Recommendation 18)
Nutrition Programs for the Elderly (Recommendation 23)
Education for Continued Living Throughout Life (Recommendation 21)
Consumer Education and Protection for the Elderly (Recommendation 19)

[4] Recommendations 17 and 20 tied with the same number of votes for each.

Appendix 3

ADDRESS BY EUGENE GULLEDGE TO FHA OFFICIALS, FORT WORTH, TEXAS, JANUARY, 1970[1]

I hope the applause was recognition of what I think is a fine staff in central office. This is the fourth meeting we have been together on and I am more and more proud. I think they are tremendous guys—objective, have a great deal of expertise, and a great desire to do the job and do it right.

I'm proud to be on the team with them.

Furthermore, I want to compliment you guys, and from the depth of your thinking and the questions you have indicated, I'm proud to be on the team with you too. As I said in my opening remarks, I think we can do the job.

Something that we have not yet touched upon, is the fact that we do have a role of educating people. We started out in FHA back in 1934 with an extremely unsophisticated building industry. The total industry reaches from not only the craftsman but up through local planning board and mortgages. Someone had to step in and be the mentor of that industry, and so far we have a long and a successful record of training people. After a while people learn and we don't have to keep teaching them. It's in that philosophy that we can find out who the responsible people are and trust them that they know what we're doing and how to draw a good plan, make a saleable product, how to build an acceptable house, how to satisfactorily subdivide land into lots, etc., and we don't need to have systems that continue to teach the informed persons, and that's the net result of a lot of what we do.

But we do have a responsibility to teach the uninformed person, and here's where I think we are failing remarkably. We just don't have adequate tools. Someone raised the point that we could do more with mobile home courts if we had something to help us tell people about it. We simply do not have an adequate set of tools for you to use in communicating with other people about our programs and how to work with us. We need to give you gentlemen tools to work with in your office, where you (I want to emphasize this) *you* will take the initiative in telling people how to do business with FHA. All the programs that I have ever been in in 23½ years were programs that somebody in industry called and FHA had a spot on the program and told people how to do business with FHA or explained some certain program. Let's get away from that. There is no reason in the world why you should always be on the builder's or the realtor's or on the mortgage banker's program. Put on your own program and invite them in. Then you control the subject matter, the conditions, the personnel, and you can teach people what it is you think they need to know. Then, of course, you can be in a position to respond to any questions they think they need to know. This, I think, would put you in an entirely different role in the community—you would be the leader rather than the follower.

But you can't do it empty handed. We are talking with our people in Washington who handle communications, PR, etc., about developing an awfully lot of training tools. We want you to be able to hold a meeting with people who would like to be mortgagees, but who really don't know our processing. We don't want you to do it on an individual basis, that would be a waste of your time. But there's no reason why you can't have a set of films, slides, charts, movies that teaches people how to process anything that you're doing that requires them to know what you're doing.

Homebuilders have put out a folder with a typical submission It's a good guide on how to process a 235, 221(d)(3), limited dividend or nonprofit sponsorship—

[1] See Chapter III, p. 27, Housing: Recalcitrant Housing Needs Still Critical.

all the forms are filled out for a typical case. Why should an outside organization like NAHB have to do that job for us? That's what we should be doing. It's the role that we should have the initiative in is what I'm trying to tell you. I think you should avail yourself of any opportunity to participate in any civic programs, civic groups, any platform, really that enables you to tell people how to do business with FHA.

Get the FHA back in people's minds in a favorable way to indicate that we are an aggressive business minded organization that knows where it's going and we can help people get there too.

There's another role, that ties in with the communicating bit, and that is the responsibility that we have of working with minority entrepreneurs.

That entrepreneur might be a mortgage banker, a plasterer, a general contractor, or an architect. We need to be aware of the fact that we have to take an active role in trying to go out and bring into the old housing industry production process, more people. And the biggest area of people who have a desire to be involved, is the minority groups. But traditionally we have depended upon trade organizations to train their own members and these minority groups, quite often, don't belong to trade associations. Or their trade associations which they have formed among themselves are fairly new and lacking in expertise. You and I have a definite responsibility to figure out how we can develop more minority businessmen and craftsmen and professionals in the housing field in the private sector. Look upon it as your responsibility of helping other people learn this business.

We're not going to produce 2.5 million units a year plus without some more producers, and the best place to get more producers is to go among those people out there who have the desire and capability but lack a little know-how. In that sense, let me talk about something else, the nonprofit sponsor and one of his side-kicks.

Apparently, in the housing act of 1961, Congress proceded on the assumption that there were certain types of housing which the private sector did not have any desire to participate as builders, sponsors, and so they devised for the first time, the nonprofit sponsor, and since then, we've found ourselves more and more working out ways to increase the role of the nonprofit sponsor in housing production. I want to have that role reversed. The nonprofit sponsor does not belong in housing production except under a very limited set of circumstances and I'll describe them with you. I've talked with the new group of National Association of Nonprofit Sponsors. I've discussed these objectives with them and they say, "Well, Mr. Gulledge, you concur perfectly with what we say, as a matter of fact here's some literature." It stated the objectives of this National Association of Nonprofit Sponsors and they say their objective is to work themselves out of business. O.K., then why do we have them? We have them because there are many parts of the country where housing is not going to be produced by majority entrepreneurs, craftsmen and tradesmen. It's going to have to be produced by minority craftsmen, tradesmen and builders. Many of them are strong on desire and weak on expertise. And it is through the umbrella of the nonprofit sponsors that many of them are able to band together to have the strength and cohesiveness to be able to learn how to do the job—how to function. There is where the nonprofit sponsor in the building portion is needed. As we developed the minority businessman (which must come first) and create a more open feeling and climate in America, then we should be able to reach a point where any business can perform a logical function and role anywhere in the country. Then the nonprofit sponsor would not need to have the role he is now fulfilling. In that sense they would like to see themselves out of business too.

That's in the role of housing production, when you come to housing management, it's an entirely different story. This Department has to develop the positive program, that as we spend the billions we should have the corresponding millions for management. We're not doing it. The Department hasn't proposed an adequate budget for counselling services. We'll never find enough money in the Treasury to build buildings so well that they will not be so abused that people won't live in them. We have to spend money on definite programs of training people to take care of property. It will do no good to build them if we can't teach people how to live in them. Working with the occupant in training and helping him, in many, many cases, is the role which the nonprofit sponsor is much better equipped to fill the need. We expect to have some additional guidelines out to you on the nonprofit sponsor qualifications that will help you to more properly evaluate whether or not your nonprofit sponsor really has the ability and has the desire and the capacity to stay with the project for an extended period of time counseling and working with training the occupants. There are

many absentee nonprofit sponsorships. The manager of the project they are sponsoring lives in Washington, D.C. They are not rendering the service counseling and guidance to the tenants. This was not the intent Congress had in mind for nonprofit sponsors. We have to find a way of delineating that role and making it a more effective one.

The "side-kick" of the nonprofit sponsor is the consultant. We have succeeded in helping create this new "profession." There's no need for a consultant. If you are doing your job, there's not one time in a hundred where any outside consultant is needed.

I had the responsibility of putting my signature on an undesirable risk determination on a consultant, and he had a bunch of projects in various stages, one in Mississippi. The sponsor called me and wanted to know what would they do since we had knocked off their consultant. So I told them to go down to Jackson and talk to the director and see if you can't work it out. To make a long story short, that's what they're doing. They took $20,000 off the cost of the project, which is the consultant's fee. With the FHA providing the help they need, it's moving twice as fast.

You ought to have the tools, the desire, and the ability, to render this kind of service. You shouldn't have to work through a consultant on a vast majority of these cases. If there remains any necessity to keep consultants, we're going to restrict their activity, the way in which they'll get their money somewhat. But more importantly, I would hope we could eliminate the need for consultants.

The basic point I want to reemphasize in the determination of markets, Washington will not determine any local markets. We want to take out of the regulations, things that tell you what your market is, and put up for you arbitrary things you have to adhere to in providing housing in your market. We want to leave these judgments up to you. We want to leave it up to you to be sure the housing needs in your area are being served and the programs that will do. I also don't want you in the local offices to *determine* the market. The market determines itself—you merely find out what it is.

We are working on the idea of insuring that a local office has the real professional capability of market analysis. What we need is a determination as to whether or not there is a need for the particular type of housing proposed. Any builder who doesn't analyze his market correctly has a lot of expensive mistakes on hand. Under our present process of conditional commitments, they don't become our responsibility until they are firm, except in the multi-family field. For that reason, we have to determine what the market is. I'm not sure you have all the help and procedures you need for that, and we want to strengthen that capacity.

One of the most vital issues is, what do you do about discounts? We saw in the Wall Street Journal that the Internal Revenue has made a new ruling that a person who pays discounts can deduct those discounts in the year in which he pays them lump sum deduction, as if they were paid interest.

We are in the processing of trying to merge a very effective organization, HAA production people with FHA production people. We are trying to find out from them what is good and useful and adopt it.

The procedures under which PHA has operated in the past have not been conducive to the expeditious handling of paper work. They tend to run on time lags that take three to five years to get something built and occupied. In contrast our nine months look real good, and I've told you I want the nine months cut to one week. For the knowledgeable responsible person, I assume we would not have to do anything a great deal differently with the HAA programs. The Housing Authority becomes a new kind of nonprofit sponsor and we simply have to work out a new way of dealing with them. There should be a uniformity of specifications whether a product is being built, a house or apartment is being built for FHA use or HAA use. The way it is produced and the product should be the same. If so HAA (and I've built under both programs), in my opinion, should get a much better value using the FHA criteria than what they are now using.

Appendix 4

EXCHANGE OF LETTERS BETWEEN SENATOR FRANK E. MOSS AND PAUL DE PREAUX, DIRECTOR, AVERY NURSING HOME, HARTFORD, CONN.[1]

CHURCH HOMES, INC.,
Hartford, Conn., July 2, 1970.

DEAR SENATOR MOSS: It has always been my belief and presumption that the Department of Health, Education and Welfare was the regulatory governmental agency on the national level whose primary purpose was to protect the rights of all citizens whose welfare fell within the purview of its charge as an agency of government. If recent events are any criteria, then I and many others find ourselves becoming completely disillusioned about both the intent and concern of the Department. The promulgation of the Title XIX standards for nursing homes printed in the Federal Register of June 24, 1969 and now the final regulations governing the "Institutional Services in Intermediate Care Facilities" published June 10, 1970, have convinced us that something is definitely awry in H.E.W. In the first instance, it required the action of your Committee on Aging and a public outcry to raise the standards from the level of absurdity to which they had been lowered. Now we find the standards for intermediate care facilities have not just been lowered, but obliterated. Rather than acting as a strong regulatory agency and assuming the mantle of leadership in concern for the care of aging, the Department of Health, Education and Welfare promulgates regulations which have the same force and effectiveness as the muttered incantations of an ancient toothless crone in a mountain cave. Neither affect nor influence anyone. The word regulation in this directive is really a laughable misnomer for we find there are no regulations, only *recommended minimums* which have no force or standing as regulation. We find this concept unbelievable because these "standards" will create a situation where once again H.E.W. appears to be sanctioning the legitimization of substandard facilities. Such legitimization can only be to the detriment of the very persons this Department was initiated to protect. We find many fascinating questions involved here.

1. Why were the Title XIX standards for nursing homes lowered last year? Was this the result of pressure from interested groups?

2. Why was the terminology of "range or level of care and services" relative to intermediate care facilities changed to completely derogate the effectiveness of the "regulation"?

3. Is this an attempt to permit those states whose nursing homes cannot comply with the new Title XIX nursing home standards to place all their substandard facilities under the protective designatory umbrella of an intermediate care facility?

4. What was so stringent about the standards for intermediate care facilities published on 24 June 1969 that now warrants the complete dissolution of any applicable regulatory standards?

5. Does the Department of Health, Education and Welfare really believe that this latest "regulation" will result in intermediate care facilities with higher standards and a higher quality of care; or are they attempting to transfer responsibility for same to the states? If so, what is the reason?

6. Will not this transfer of responsibility necessarily result (in some areas) in the care of the elderly being gauged by the available welfare dollar rather than on the needs of the individual and transferring the onus for this arrangement to the individual state rather than on the Department which is instigating the situation?

[1] See Chapter IV, p. 41, Increasing Concern Over Nursing Homes.

7. For a change, did the Department of H.E.W. request the opinions of any of the administrative heads of the state regulatory agencies to determine the need for and potential efficacy of this latest "regulation"?

8. Why wasn't this "regulation" reviewed for comment by the National Association of Health Facility Licensure and Certification Program Directors, an official affiliate of the Association of State and Territorial Health Officers? I am forwarding a copy of this letter to Mr. Jarvis, secretary/treasurer of the aforementioned organization for comment and review by the members of this Association at their next meeting on July 17, 1970 to be held in New Orleans, Louisiana.

There may be some very logical and good reason for this "regulation". However, we feel that the answers to these questions should make interesting reading. In practical reality, we find that H.E.W. appears to be attempting to divest itself of all responsibility for regulatory action not only as regards facilities, but also in the area of quality of care.

After two attempts by the Department of Health, Education and Welfare to lower Title XIX standards, we can only ask the question: "Is this because of incompetence, political expedience, or design?" If it is the last, we would appreciate knowing the reasons for same; for on the surface it appears that the concern for the welfare dollar has replaced the concern for the welfare recipient. We hope that this is not so; for if any agency of govenment should be the agency of concern, it is Health, Education and Welfare. We do not feel that it can abrogate its assigned responsibility or authority without good reason.

We hope, sir, that you will again try to reverse this seemingly continuous effort to replace "concern" with "cash."

Sincerely,

PAUL DE PREAUX, *Director*,
Avery Nursing Home.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
MEDICAL SERVICES ADMINISTRATION,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., September 21, 1970.

DEAR SENATOR MOSS: This is in further reply to your letter of August 18, 1970 and the letter to you from Mr. Paul de Preaux which you enclosed. You asked specifically for our comments on questions raised by Mr. de Preaux concerning the amended regulations for the intermediate care program published on June 10, 1970.

Mr. de Preaux asked why provisions relating to "range or level of care and services" were changed. He further asked what was so stringent about the standards for intermediate care facilities published on June 24, 1969 "that now warrants the complete dissolution of any applicable regulatory standards." The issue involved in the amendment of the June 24, 1969 regulations was not related to the stringency of the standards or to the desirability of Federal standards for this type of facility. The basic issue was whether the statute intended that standards for intermediate care facilities be established by State rather than Federal authority.

Section 1121 (e) of the Social Security Act defines an intermediate care facility as:

> "an institution or distinct part thereof which (1) is licensed, under State law, to provide the patients or residents thereof, on a regular basis, the range or level of care and services which is suitable to the needs of individuals described in subsection (b) (2) and (3) . . . . .", i.e. those individuals who
>
> "(b) * * *
>
> (2) because of their physical or mental condition (or both), require living accommodations and care which, as a practical matter, can be made available to them only through institutional facilities; and
>
> (3) do not have such an illness, disease, injury, or other condition as to require the degree of care and treatment which a hospital or skilled nursing home (as that term is employed in title XIX) is designed to provide."

The report of the Senate Committee on Finance on the Social Security Amendments of 1967, in which section 1121 was enacted, included the following statement on page 189:

"Intermediate care homes would be defined and licensed by States and would be those institutions which provide services beyond ordinary board and room but below the level of skilled nursing homes."

In developing the original regulations it was felt that the Federal government was responsible for establishing the minimum specifications for the range or level of care and services suitable to the needs of eligible individuals. However, shortly after the publication of the regulations in June of 1969, legal authorities in certain States questioned whether the inclusion of such specifications in Federal regulations was consistent with the statutory language which defined an intermediate care facility as one "licensed, under State law, to provide . . . the range or level of care and services . . ." and requested a review of this question by the Department. After extensive review within the Department, it was decided that the law intended to reserve the establishment of standards for intermediate care to the States. Accordingly, the regulations were amended and the standards previously issued relating to the range or level of care and services were retained as recommendations.

In answer to question No. 5 in Mr. de Preaux's letter, we cannot assure that the regulations will result in intermediate care facilities with higher standards. We hope, however, that State agencies will observe the Department's recommendations for minimum standards and, indeed, improve upon them. The amendment of the regulations *was* a transfer of responsibility to the States; or, more precisely, a restoration to the States of responsibility which Congress intended for the States to exercise. We do not believe that the transfer of responsibility for standard setting in intermediate care will necessarily result "in the care of the elderly being gauged by the available welfare dollar rather than on the needs of the individual. . ." Limitations on service caused by limited State budgets is a problem and a challenge to State administration in all of the public assistance programs. However, we cannot accept the proposition implicit in this question that program abuse inevitably follows the assignment of responsibility to State agencies.

The original regulations for intermediate care were circulated before their final publication on June 24, 1969 to all of the States for their advice and comments. Neither the State agencies nor the National Association of Health Facility Licensure and Certification Program Directors was consulted before issuance of the amended regulations in June of this year. It was determined that such consultation would not necessary or appropriate since the issue on which the change was based was exclusively a matter of interpretation of Federal law and Congressional intent.

For your information, earlier this year the responsibility for administration of the intermediate care facility program was transferred from Medical Services Administration to Assistance Payments Administration of the Social and Rehabilitation Service.

I trust this will provide you with the information you need.

Sincerely yours,

HOWARD N. NEWMAN, *Commisisoner.*

CONNECTICUT ASSOCIATION OF NONPROFIT HOMES
AND HOSPITALS FOR THE AGED,
OCTOBER 30, 1970.

DEAR SENATOR MOSS: We are in receipt of your letter of 9 October 1970 and the enclosure, dated 21 September 1970.

Sometimes, sir, we are astonished by the apparent consistency of HEW's interpretive inconsistencies.

Mr. Newman's letter states in paragraph 2. page 1 that:

"The basic issue was whether the statute intended that the standards for intermediate care facilities be established by the State rather than Federal authority".

As authority for this decision and determination that the States should be accorded this regulatory function, he quotes the following:

"Section 1121 (e) of the Social Security Act defines an intermediate care facility as:

"an institution or distinct part there of which (1) is licensed, under State law, to provide the patients or residents thereof, on a regular basis, the range or level of care and services which is suitable to the

needs of individuals described in subsection (b) (2) and (3) . . . .", i.e. those individuals who

(b) * * *.

(2) because of their physical or mental condition (or both), require accommodations and care which, as a practical matter, can be made available to them only through institutional facilities; and

(3) do not have such an illness, disease, injury, or other condition as to require the degree of care and treatment which a hospital or skilled nursing home (as that term is employed in title XIX) is designed to provide".

The usage of this section to justify the transfer of the regulatory function to the States becomes even more confusing when one finds that almost identical terminology was used to justify Federal regulatory standard setting for "skilled nursing homes".

Section 249.10(a) (4) (i)

A "skilled nursing home" is a facility, or a distinct part of a facility; which meets the following conditions:

(h) The facility is licensed or formally approved as a nursing home by an officially designated State standard-setting authority and effective July 1, 1968, has not been determined by such authority not to meet all requirements of the State for licensure as a nursing home".

We are aware that legal opinions can differ, but we find opposite conclusions reached based on the same criteria rather more than far-fetched.

In paragraph 2, page 2, it is indicated that "various States questioned the legal authority of the Federal Government to set standards". Perhaps, we were wrong but it has been well publicized that only the welfare department of one State, Nebraska, opposed the standards. Further, we have it on good authority that many HEW officials had and still have misgivings about the correctness of the Department's decision.

In paragraph 3, page 2, the statement is made that HEW cannot accept the implicit proposition that program abuse inevitably follows the assignment of responsibility to State Agencies. Neither do we imply that all States will necessarily lower standards, but the possibility now exists if this decision stands. Does HEW deny the potential for lowered standards? Has it found that lack of minimum standards on the part of the Federal Government results in higher standards? If only one State allows the licensure of substandard facilities, then who is the culprit—the states who maintain low standards or the Department which abrogated its authority to set minimum standards? From past experience, we doubt that standards would be raised in many States as a result of this decision.

Rather than dissect the enclosure paragraph by paragraph, we will ask only one more question concerning its content. Since this decision affects all State agencies and the National Association of Health Facility Licensure and Certification Program Directors was set up primarily to review and comment on issues such as this, why were they not consulted? We find it incomprehensible that they were not consulted—and so, I might add, do they. The reason given in paragraph 1, page 3, for not consulting them we find imperceptibly convincing.

As we said in our primary letter, we thought the answers forthcoming would make interesting reading. It has been so! In our opinion the justification for the action taken is based on very tenuous legal grounds. Further, we cannot believe Congressional intent was to allow fifty different definitions of "intermediate care facilities" without minimum regulatory standards set by the Federal Government, especially since millions of Federal dollars are involved. We cannot believe Congress would demand other than State compliance with minimum standards, not minimum recommendations.

Rather than repeat ourselves, we still advance the same objections listed in our primary letter since it is our sincere opinion that this action by HEW can result in lowered standards and ill-service to our aged.

Sincerely,

PAUL DE PREAUX,
President, CANPHA.

Appendix 5

NUTRITION AND ACTIVITIES IN MASSACHUSETTS

ITEM 1: CHAPTER ON "ELDERLY NUTRITION PROGRAM" EXCERPTED FROM INTERIM REPORT OF THE SPECIAL COMMISSION TO MAKE AN INVESTIGATION AND STUDY RELATIVE TO HUNGER AND NUTRITION IN THE COMMONWEALTH AND CERTAIN RELATED MATTERS, BOSTON, MASSACHUSETTS, MARCH 26, 1970

VI. Elderly Nutrition Program

The lack of proper nutrition is not unique to a certain age group or time of life. *Certain vulnerable groups, however, have been pinpointed, survey after survey, as having particularly distressing nutrition problems. One such group is the elderly of which it is estimated over 600,000 reside in Massachusetts.*

Many factors contribute toward making the elderly particularly vulnerable to poor or inadequate diet. Some are directly related to health, some to available funds, and all to age. As Mr. Collins, a member of the Cambridge Council of Elders said at a hearing, there is a "lack of understanding of the problems of older citizens for needed health care and nutrition". The particular problems that affect the aged are:

—lack of appetite
—poor teeth or general poor physical health
—loneliness and despair
—fear of crime in the streets: not going out to buy food
—lack of energy to shop for food
—lack of energy to prepare food
—lack of cooking facilities; inadequate storage facilities
—difficulty in shopping and/or cooking for one person
—bad eating habits
—lack of adequate income, e.g., high rents.

As Marilyn Ross, Dietician at Peter Bent Brigham Hospital and Senior Citizens Chairman of the Food, Education and Information Committee, and Mrs. Dorothy Mascoop, Nursing Home Consultant and Nutritionist with the Council of Elders, Roxbury, related to the Commission at its hearing devoted entirely to the nutritional needs of the elderly, these problems often result in the elderly surviving on a "tea and toast" diet. In addition, said Mrs. Ross and Mrs. Mascoop, "diets for elderly people tend to be low in protein and iron and high in carbohydrates. Due to a decreased intake of fruits and vegetables they lack Vitamin A and Vitamin C. Also a decreased intake of milk leads to decreased calcium and osteoporosis. Due to the use of unenriched flour products they lack vitamin B. Nutrition needs of the elderly are the same as an adult but there should be a decreased amount of calories with the decreased amount of physical activity that usually accompanies old age." Often this is not the case.

The Commonwealth presently has programs operating which are aimed specifically at alleviating the nutrition problems of the elderly. Improvements in these programs are needed and expansion is necessary for others. In addition, there is an overriding need for new, innovative thinking in relation to the nutrition problems of the elderly.

A. School Hot Lunch Program for the Elderly

The hot lunch program for the elderly resulted from legislation originally filed by Senators Maurice A. Donahue, Samuel Harmon and William Weeks, in 1967 (Chapter 855, Acts of 1967) authorizing ten municipalities to undertake a pilot program in feeding elderly citizens in school cafeterias after the chil-

dren's lunch period. This law enabled public or private schools to prepare and sell meals through their school lunch program to persons over 59 years of age at a cost of 50c per meal. The Massachusetts Commission on the Aging and the Department of Education worked to promote this program.

During the past legislative year this original 1967 law was amended to permit all cities and towns in Massachusetts to participate in this program. (Acts of 1969, Chapter 703). There are now 12 cities and towns (with another 15 authorized before the end of this school year) prepared to meet the eligibility requirements to inaugurate this project. In the past 1968 school year, 37,431 meals were prepared with an average of 124 lunch days observed. The average cost of a meal was 72c with the additional cost over 50c reimbursed by a $1500 federal grant available for a two year period.

(1) The Commission recommends that the governing body of each city and town must develop a plan for year-round hot lunch program for the elderly with a particular emphasis in areas of need.

(2) This Commission goes on record in support of repealing the means test for school lunch programs for the elderly.

(3) The Commission recommends that the Bureau of the Aging within the Department of Community Affairs become a division of the aging with its own deputy commissioner and that this new division establish a senior citizens corps able to help others of their own age in school meal preparation and supervision.

B. Decentralized Feeding Programs

1) BULK CAFETERIA STYLE DECENTRALIZED FEEDING PROGRAM OR SATELLITE PORTION OF THE ELDERLY HOT LUNCH PROGRAM

In this program food is prepared in the school kitchens and transported to convenient, more accessible locations for the elderly. Often these locations are in housing projects, churches, central meeting halls, and the like. In Malden, for example, the program is presently being operated in a church hall located in an Urban Renewal area where a great number of the elderly reside. The meals cost the recipient 50c and often provide the only nutritious meal for the day. In addition to this low cost midday meal, the centers provide a variety of educational, cultural and social activities for the elderly. At present this program operates in Malden and Pittsfield.

(4) The Commission recommends expansion of the bulk-decentralization food program so that schools as well as other non-profit agencies may take part in the program.

(5) The Commission encourages the institution of a nutrition and health program during these lunch periods where meals are prepared and served.

2) INDIVIDUAL MEALS-ON-WHEELS OR MOBILE KITCHEN PROGRAM

In this program the meals are prepared in the school cafeteria on individual thermo-trays, put in metal insulated cases and transported to the individual dwelling units of recipients. These recipients are usually too old or infirm to leave home. In some instances the trays are dropped at a common room of a housing project and volunteers deliver the trays to designated apartments.

Pittsfield has operated a meals-on-wheels program since 1968 and has built up a sizeable volunteer corps to aid in delivering meals for shut-ins. The Council of Elders operated a highly successful mobile meals program in a limited area of Roxbury. The program is now entering its second year. At times more than 200 meals have been served in one day delivered by a mobile unit directly to the homes of elderly persons. Both regular and special menus are available to fit certain health requirements. One need not be poor to participate in this program. The only requirement is that participants be over 65 years of age and in need of physical aid.

(6) The Commission recommends that private facilities be utilized also for cooking the meals-on-wheels lunches.

(7) This Commission recommends that the Federal Government, in line with the White House Conference on Food, Nutrition and Health Recommendations, undertake permanent funding programs of daily meal service, initially consisting of at least one meal for all the aged.

In addition:

(8) The Commission recommends that elderly State housing projects be built with central common rooms and central cooking facilities.

(9) This Commission recommends that the Federal Government in line with another White House Conference recommendation revise the present food stamp law to enable the elderly to purchase prepared meals with stamps.

(10) The Commission recommends that the new Division of the Aging along with the Office of School Lunches in the Department of Education seek ways of providing necessary transportation for the elderly who are not within reach or not able to use normal public transportation in order to take advantage of nutrition programs, such as the school hot lunch program.

ITEM 2: TEXT OF LEGISLATION AUTHORIZING BROADENING OF MASSACHUSETTS SCHOOL MEAL PROGRAM FOR ELDERLY [1]

CHAPTER 753—THE COMMONWEALTH OF MASSACHUSETTS IN THE YEAR ONE THOUSAND NINE HUNDRED AND SEVENTY

AN ACT—Providing for the participation of certain public and private schools, and other nonprofit public or private agencies, in a school lunch program for elderly persons.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 15 of the General Laws is hereby amended by inserting after Section 1K the following sections:

SECTION 1L. The school committee of any city or town designated by the division of social and economic opportunity in the department of community affairs may extend the school lunch period for the purpose of serving lunches to authorized elderly persons. Private schools in any city or town so designated may also participate.

The governing body of each city and town shall be responsible for developing a plan for a year round hot lunch program for the elderly.

The bureau of nutrition education and school food services in the department of education may contract with nonprofit public or private agencies for the preparation and serving of meals to the elderly in accordance with the provisions of this section.

Such meals may be prepared by schools and nonprofit agencies and served on site or in central production centers for service at sites more convenient to the elderly.

The operation of such school lunch programs by public or private schools and nonprofit public or private agencies shall be subject to the following conditions and restrictions:

(1) The charge to such persons for each lunch shall not exceed fifty cents.

(2) The lunches served shall meet the nutritional standards established by the department of education.

(3) The procedure determined by such school committee or such private school in serving such lunches shall be approved by the division of social and economic opportunity in the department of community affairs and the bureau of nutrition education and school food services in the department of education.

(4) The division of social and economic opportunity in the department of community affairs shall provide each such person with an identification card authorizing his participation in such lunch programs.

As used in this section, the words "authorized elderly persons" shall mean persons over fifty-nine years of age whose participation in the program has been approved by the division of social and economic opportunity in the department of community affairs. The commonwealth may, subject to appropriation, reimburse any city or town, public school, private school or nonprofit public or private agency for such costs, excluding any costs for equipment, as are incurred in excess of fifty cents for each such lunch prepared and served, upon written request by such city or town, public school, private school or nonprofit public or private agency to the commissioner of education on such form as he may prescribe. If the commissioner approves such request, he shall certify to the comptroller that such payments are due and the state treasurer shall pay the

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[1] See Chapter V, p. 65, Nutrition and Other Consumer Issues.

same. Any federal funds provided annually for the purposes of this program shall be expended prior to the use of any funds appropriated by the commonwealth.

SECTION 2. Chapter seven hundred and three of the acts of nineteen hundred and sixty-nine is hereby repealed.

House of Representatives, August 13, 1970. Passed to be enacted.

THOMAS W. MCGEE, *Acting Speaker.*

In Senate, August 17, 1970. Passed to be enacted.

KEVIN B. HARRINGTON, *Acting President.*

Approved, August 24, 1970.

FRANCIS W. SARGENT, *Acting Governor.*

Appendix 6

"FIRST READER" ON WHITE HOUSE CONFERENCE ON AGING, PROVIDED BY THE ADMINISTRATION ON AGING [1]

1971 WHITE HOUSE CONFERENCE ON AGING

FIRST READER

Today I am issuing a formal call for the second White House Conference on Aging to meet in Washington, D.C., in November of 1971. With careful advance planning and with broad, representative participation, this Conference can help develop a more adequate national policy for older Americans. I hope that it will fully consider the many factors which have a special influence on the lives of the aging and that it will address precise recommendations, not only to the Federal government, but also to government at other levels and to the private and voluntary sectors as well.

PRESIDENT RICHARD NIXON.

White House Conference on Aging Statement, October 6, 1969

FIRST: THE FORUMS

The older people met together and they talked about not being wanted.

"We've always had problems but it seems like the problems get worse the older you get."

They said that they needed money and could still work but . . .

"The way it is now, if you work, you're penalized."

They said an elderly person living on insufficient income simply had to let some things go. They said often these were medication, visits to doctors or hospitals, home repairs, and balanced diets.

"It is very difficult to have nutritious meals on $30 a month."

They said they needed more health protection. They said Medicare did not pay for the prescribed medicines they needed or the really long-term care.

They said that many of them lived in bad housing conditions.

They said that, lacking transportation, they could not go to the doctor, buy food, visit friends.

They said real estate taxes were too high.

And in many places they were afraid, afraid to leave their homes, afraid of what might happen to them tomorrow, next week, next year—not afraid of death but of what might happen to them in life.

"Our greatest fear is being unable to take care of ourselves."

But one man in Minnesota said, "We are assets, not liabilities. This group will get nowhere unless we join forces in this battle that is so just and so necessary at this time. Our community was built on the backs of the people in this room."

They voted and the votes were counted. They talked and were listened to and voted and were counted. That last was very important. . . . They *were counted.*

The "listening to" was important too because the people who listened were often able to do something—

In one town in Texas chairs have been placed in department stores where older people can rest when they are shopping.

In a Michigan town, a city commissioner is looking into the possibility of hiring older people for city jobs.

[1] See chapter XI, p. 129. The Role of AOA—Or a Successor.

In New Jersey, two Boards of Freeholders have passed resolutions to establish county offices on aging.

The mayors, councilmen, doctors, business executives, real estate people, program and agency administrators—and legislators—listened. Things are happening. Something is being done.

SECOND: COMMUNITY CONFERENCES

In February, March, and April 1971, again at the grass roots, in the local communities, the home towns of the 20 million men and women who built the towns and so the country....

This time the meetings will be more formal—community White House conferences on aging—and the power structure of the communities, the professionals in the field of aging, the people who provide services, and the local "doers" will sit down with older people—people 75 and older, people between the ages of 60 and 74, and people not yet so old, between the ages of 45 and 59—and with young people to consider those September-October votes.

A surprising number of the "doers" are also older people. They built America—a country interested in advance—and so they are not asking to go back to the way it was in the "good old days." But they want to continue to take part in the building and advancing. They are not resisting change but they want it to include them.

As one man said in September, "We want to be doing something from which we have a little return, not something just to pass the time. Just passing the time is part of the problem."

The community conferences are charged with a most important step in the long process of preparation for the national White House Conference on Aging.

They will take the wishes and pleas and suggestions which came from the hearts in September and frame policy proposals—possible solutions to the needs the forums showed—and present them to the next level—the State.

To help them they will have the report on needs from the fall forums and background papers on those needs, prepared by specialists. Technical committees of professionals will have worked to pin-point the major issues which must be solved and these will also be available.

The process is a long one because—unlike the 1961 Conference that produced 600 recommendations, so many that few could be acted on—the 1971 Conference has been asked by the President of the United States to formulate a national policy on aging. It must come up with a broad plan, comprehensive enough and practical enough to make the later years of life worth living—pleasurable for the people who live them and productive for their country.

The next two pages are a flow chart showing major activities leading to the 1971 White House Conference on Aging and the dates when they are scheduled to take place.[2]

THIRD: STATE CONFERENCES

In almost every State in May 1971—Senior Citizens Month, the most important Senior Citizens Month yet—a State White House conference on aging will be held. Of the two States not holding their conferences in May, one will hold regional White House conferences then and the other will hold its conference earlier, probably in late April.

At this point in time, recommended national solutions to local problems must begin to emerge. The needs voiced by older people, with the major issues outlined by professionals, will have been discussed at community conferences and tentative solutions drafted. At the State level, these must be weighed, balanced, evolved into recommended policies that will have impact and direction.

Before each State conference, groups of citizens in the State in task forces will work to combine proposals from that State's community conferences and to word them as clearly as possible.

Delegates at the State conferences will have these policy proposals to start their deliberations. The major recommendations that grow out of these State discussions will go forward to Washington. Delegates may not all agree—minority opinions will also be forwarded.

Who will the delegates at State conferences be?

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[2] See chart, p. 140.

Many of them will already have attended the forums or the community conferences—thus already proving their concern for the aims of the 1971 Conference.

Some will come from rural areas, from farms or ranches; others from central cities, suburbs, or towns. Some will have wealth and power. Some will be poor.

Some will be research scientists, teachers, nursing home administrators, health and welfare officials, social workers, doctors, volunteers, young people. Many will be retired and living on pensions, social security benefits, old-age assistance payments.

All will be committed.

Age—if it can be a time of reward and not punishment—is something every one can hope for. Not older Americans alone but all Americans should be concerned with what awaits them in their later years. Since all Americans cannot attend the State conferences on aging this May, their representatives must be drawn from all age groups, all economic levels, all geographical areas, all minority groups.

Toward a National Policy on Aging

Even as the forums and conferences in communities and States are taking place, other groups are working toward the national Conference.

Report on Needs

A tabulation of answers to the needs questionnaires distributed at the fall forums and a publication based on the reports from forum recorders will both be available for the use of delegates at community and State conferences.

Issue Papers

Last summer specialists on aging began to write background papers outlining the present situation for older people in regard to—

Income	Housing	Health
Nutrition	Education	Transportation
Retirement roles and activity	Spiritual well-being	Employment and retirement

Papers were also prepared telling what has been done, and what has not been done, for older people through—

Services, facilities, and programs
Planning and evaluation
Training
Research and demonstration
Government and nongovernment organizations

During the fall of 1970, 14 technical committees, composed of informed professionals, were appointed to study these background papers and to pinpoint the major issues to be discussed by delegates to community, State, and national conferences.

Each issue is a question, which can be resolved in once or more ways. The issues will provide a focus on the major problem of older people and hold down the number of recommendations produced by the conferees to a manageable number.

National Organizations

Nearly 400 national organizations are planning to participate in the 1971 White House Conference on Aging.

Many of these organizations have appointed representatives to task forces to make policy recommendations on income, housing, health, nutrition, education, transportation, retirement roles and activities, spiritual well-being, and employment and retirement of older people.

Recommendations developed by these task forces will be combined by the technical committees with those from State conferences for the use of the delegates to the national Conference.

National organizations are also urging their members to become involved in the community and State White House conference on aging.

WHC Planning Board

The Conference Planning Board, which has the responsibility for advising the Conference Director on the preparations for, and conduct of, the national Con-

ference, met for the first time in October and will meet at least twice more before the Conference delegates gather in Washington.

The Board is itself broadly representative.

Regional Hearings

During the months of January through April, Regional Councils consisting of staff members from the regional Offices of the Federal agencies with programs to help people—HEW, OEO, Labor, HUD, and Small Business—will be helping to organize regional hearings throughout the United States.

Testimony taken on needs and possible solutions to those needs will be sent to Washington to add this input to the overall background.

1971 White House Conference

The 1971 Conference will be held at the Washington Hilton Hotel, in the week beginning November 28. Delegates from all States and Territories and from national organizations will meet together during those days to draft a national policy on aging.

That national policy should be a comprehensive plan for action for older people. Each recommendation in it—each component of the blueprint—must be tested against these criteria :

Is it based on knowledge and the recognized needs of older people?
Is it consistent with established national goals and the values of society?
Is it feasible in terms of current knowledge, technology, and manpower?
Is it clear?
Is it realistic in terms of present and future costs?
Will the general public and the decision-makers support it?
Will it benefit other elements of the population?
Will it preserve the dignity, freedom, and right of choice of older people?
Does it fix responsibility for action on a specific institution or agency?

The Post-Conference Year

With a national policy on aging based on these criteria, or even most of them, all individuals concerned about older people will have a clear mandate for action.

After the Conference in 1972, a report of its recommendations will be presented to the President of the United States. In the following months, legislation will be prepared for submittal at all levels of government.

But this will be only the most visible effect of the Conference. Thousands will have participated during its 3 years, but millions will have learned something about the lives of older people in America—their needs and their aspirations.

Beginning with older people and bringing in others from all walks of life, all ages, in a truly democratic process, the 3 years of the Conference will bring about other changes than those prescribed by law. As attitudes change, as officials listen, as communities and States work out solutions, some needs will begin to be met even before the Conference is concluded.

Appendix 7

NUTRITION FOR AGING

WHITE HOUSE PANEL, AoA, CHART MOVES ON NUTRITION FOR AGING [1]

[Article From Sept.–Oct., 1970 Issue of AGING (Published by the Administration on Aging)]

A meeting to plan next steps to implement recommendations of the Panel on Aging of the White House Conference on Food, Nutrition, and Health (*Aging*, Feb.–Mar. '70, p. 19) was held in Washington Aug. 7 and 8.

Participating in the meeting, which was called by the Administration on Aging, were members of the original Panel, representatives of the food processing and food service industries, and government researchers and officials. The group reviewed developments since the close of the White House Conference, and proposed a number of steps for the near future.

It focused attention on the Panel recommendations covering meal delivery, food stamps, housing and dining facilities, packaging and labeling of consumer commodities, and education, research and development.

John B. Martin, Commissioner on Aging, accepted the recommendations and said AoA will follow them as rapidly as possible.

The first step toward development of nutritionally adequate foods, conveniently packaged and labeled with useful nutrition information, is agreement upon the nutritional standards and specifications to be met.

AOA TO COORDINATE

Commissioner Martin said his agency would coordinate with other agencies of government, industry, science, and the professions to achieve this agreement. The Food and Nutrition Board, National Research Council, was suggested as a resource in this undertaking.

The meeting also noted that costs of producing new and convenient nutritional foods should be carefully estimated and efforts to reduce costs should be expanded. The older person frequently has very limited funds for food purchases.

It was agreed that "geriatric" foods should not be developed, that new foods should be available and attractive to all consumers, but should meet the nutritional needs of older people. Moreover, they should be packaged with thought to ease of preparation with the restricted cooking facilities available to many older people.

Promotional materials for these new foods can and should also be used for nutrition education and to combat food faddism, the conferees said.

It was urged that the elderly have choices for food purchase, service in group settings of at least one meal a day, and delivery of food for the homebound, should be available seven days a week, 365 days a year, to all elderly people. To achieve this goal, public funding on a continuing basis was termed essential.

Other recommendations were:

As in the school lunch program, guidelines to protect the nutritional quality of meals for the aged should be developed. In providing meal service, each community should consider the ethnic and cultural needs of the group served.

Development of food service programs must be flexible, in order to use all available community resources. All programs, however, should provide nutrition education. Special efforts to bring the service to the isolated older person should be made.

The Administration on Aging, which is now supporting 22 demonstration projects, continue to evaluate these meal delivery programs in order to maximize their benefits at the lowest possible cost.

The AoA should urge upon the Department of Housing and Urban Development the importance of group dining facilities in all new and renovated housing for older people. The meeting participants noted that if such facilities are included in all plans their construction would require a minimum of additional cost.

[1] See Chapter V, p. 65, Nutrition and Other Consumer Issues.

Appendix 8

REPORT OF THE TASK FORCE ON MEDICAID AND RELATED PROGRAMS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, JULY 29, 1970

SUMMARY

The Task Force has examined the deficiencies of title XIX (Medicaid) and related programs, as well as considerations involved in financing health services over the long term. It has recommended specific courses of action and a strategy for the future direction of the health system.

The scope of the inquiry was broad; neither the purposes nor design of government programs can be comprehended adequately in today's environment without reference to the health system as a whole. The Task Force sees the current system, overall, as a vital part of the American culture and economy, involving vast investments in acute care and related biomedical research. At the same time, the Task Force sees serious flaws in the system that appear in particularly bold relief against the background of an economic and political structure able, if willing, to cope with them. In essence, significant numbers of people do not have adequate access to care and the services of many who do are so far below the mark, with reference to the potential productivity of the system, that the credibility and accountability of the system itself is at stake.

The report contains recommendations under these headings:

Eligibility and Protection under Existing Financing Programs;
Effecting Changes and Improvements in the Delivery of Health Care;
Management of Health Activities;
Consumer Participation;
Comprehensive Health Planning;
Long-term Care; and
Long-term Financing Policies.

The recommendations vary widely in nature and scope. Some of them deal with the logistics of implementation. A critical few call for major changes in the orientation and strategems of the total health system without which, the Task Force is convinced, revision of title XIX and related programs would be ineffectual and unproductive. No attempt is made, in this summary, to repeat all recommendations made in the text. The major ones are cited in the context of themes derived from the debate of one year and set forth in the Introduction to the Report.

SIGNIFICANT DEFICIENCIES IN ACCESS TO CARE

Even after 4 years' experience under Medicaid and Medicare, and with parallel opportunities for expansion in the private sector, a significant number of Americans are not adequately protected against the costs of needed health services. As a direct result, too many do not get services they need.

Approximately 26 million people in the United States live below the poverty line (about $70 a week income for a family of four) and approximately 15 million more are near-poor ($90 a week income for a family of four). Only 13 million will be covered by Medicaid in 1971. Less than 30 States, despite the availability of Federal matching money, have programs for persons who are medically needy but do not qualify for cash assistance. Two out of three children in poor or near-poor families are not included under Maternal and Child Health or Medicaid programs. Among the poor and near-poor, only a little over a third below the age of 65 have private prepaid medical care or medical insurance of some sort. In total, depending on different estimates, between 30 and 45 million people under age 65 are without any health insurance to speak of. The stated

objective of Medicaid was to assure adequate health care to the Nation's poor and near-poor. If this continues to be a primary goal—and the Task Force believes emphatically that it should—a considerable improvement in financing and delivery capabilities will be required.

We recognize that expenditures on behalf of those now lacking purchasing power and services will add initially to the problems of inflation within the health field. But against this, a double standard for a service so deeply rooted in human compassion and so essential to a productive community cannot be tolerated.

Moreover, there remains the prospect that if the new money, joined with other government and private means, is spent more wisely than in the past, inflation can be minimized. To redeem the promise of Medicaid and help give meaning to the declaration that access to medical care is a right to all within the context of current legislation:

> We recommend converting Medicaid to a program with a uniform minimum level of health benefits financed 100 percent by Federal funds, with a further Federal matching with States for certain types of supplementary benefits and for individuals not covered under the minimum plan. There should be maintenance-of-effort requirements upon the States to retain at least their present expenditure levels.
>
> First priority for protection under a basic Federal floor for Medicaid should be all persons eligible for payments under the proposed Family Assistance Plan. Additional groups should be phased in until all persons with incomes at or below the poverty line are covered.
>
> The disabled social security beneficiaries should be included as soon as possible under title XVIII.
>
> Legislative changes are needed to establish Federal responsibility for the cost of medical care and services for migrant workers and other eligible people who do not have established residence in any State; migrant workers should be eligible for the benefits of title XIX.

Several recommendations are made to improve the operation of title XIX, e.g., use a dignified and simplified method of determining eligibility and payment; give greater protection to clients who are dissatisfied with actions or failure to act; make information about the program more widely and forcibly available; eliminate discriminatory practices by providers, guaranteeing the care of persons without permanent residence in any State.

Other recommendations are directed at the private sector to improve the coverage, scope and efficiency of benefits. For example, means are proposed to improve the protection of employees during short periods of disability or layoff, small groups and self-employed individuals, part-time and temporarily employed persons. Strong encouragements are given to greater exploitation of the work environment for health education and prevention programs.

IMPROVING DELIVERY OF HEALTH SERVICES

In the light of rapidly rising costs and troublesome inflation in the health field, the recommended addition of new expenditures through expanded and improved financing programs, and the need for all to have more readily accessible services, it is essential to improve the delivery of health services.

The Task Force has concluded that the necessary changes in a myriad of personal transactions among consumers and providers will not come about simply in response to the interaction of consumers' interest and provider self-interest. If sufficient changes in effectiveness and efficiency are to be achieved, much bolder interventions will be needed than we have seen to date. These must be in the form of public policy reinforced through more aggressive management.

It is a central conclusion of the Task Force that money is needed, but that money alone will not guarantee either capacity or effectiveness of the system. In fact, if a benevolent and affluent government were to begin to pay for all the basic health care needed by all those who can't pay for it themselves, but no other change were introduced into the existing system, the result would be a disastrous rise in the cost of services that are already scarce.

There isn't enough money and there aren't enough doctors to provide the needed care just on a fee-for-service basis; thus, any solution will require new options, new goals, and new attitudes. Without these, the health system cannot

move forward to meet its growing responsibilities; with them, the Task Force is convinced that the recommendations in this Report, most of which relate in one way or another to this basic issue, can show the way toward achieving more and better health care for all Americans.

For two decades programs financing medical care, whether public or private, have been reinforcing traditional ways of providing service. The Task Force is convinced that it no longer makes sense to keep pouring new wine in old casks—some of which are leaking. Additional financing must be accompanied now with opportunities and encouragement to physicians, hospitals and others to provide service in ways that permit a logical response to sound economic and patient-care incentives, and to engage in a competition of organization and method.

The concept of planned intervention can be organized in three interacting and interdependent categories; more responsible purchase of services, better management of health services, and broad concept of health care. Some basic recommendations follow under each.

More responsible purchase of services

The methods of purchase and conditions of participation in Medicaid and Medicare and the investment policies of all Federal financing programs, with corresponding actions in the private sector, constitute powerful instruments for achieving increased capacity and new organizational patterns in the delivery of health services.

The Federal Government should provide leadership and funds to create and support systems of health care, through a variety of auspices and approaches, that will contain the following desirable elements:

Comprehensive services and continuity of care,
Contractual services for definable population groups,
Integrated fiscal and managerial responsibility, and
Risk sharing through prepayment.

Legislation should be enacted to make sums equivalent to 5 percent of Federal Medicaid appropriations per year available for the development and improvement of health-care services and resources.

These funds should be expended as "front-end" money to create new or expanded capacity for service in localities with a high proportion of low-income persons and where the need for development and/or improvement of health-care resources has been determined in cooperation with State and areawide comprehensive health-planning agencies.

To support the development of needed services, priority should be given to: development of organized primary health-care services in neighborhoods, development of services and resources which can serve as alternatives to inpatient hospital care, e.g., home-health-care programs; improvements in utilization, efficiency, and/or quality of existing health services directed toward producing more and better health care; social and other outreach services which are an integral aspect of appropriate utilization of services; development of ways to link and relate new and existing health services with each other, aiming toward comprehensive health-care systems in communities. Consideration should be given to legislation which would provide a percentage of Medicare funds for similar supply-influencing efforts.

In order to encourage the use of efficient, innovative, and effective delivery systems, legislation should be enacted to provide the Secretary with discretionary authority to modify the Federal share of Medicaid payments for certain services to the States, by providing increased Federal funds of 5 to 10 percent above the usual matching formula on a differential basis. The higher payments would be made to those States which successfully develop and use such services and payment methods as contract payments to prepaid group-practice plans, neighborhood health centers, and other arrangements for provision of comprehensive services to a definable population, or use of new types of health manpower and paramedical manpower.

All appropriate sources of Federal funding, in particular the National Center for Health Services Research and Development and the Partnership for Health Programs, should be encouraged to give high priority to development support and demonstrations of model health-care-delivery systems.

To provide facilities for these programs, the Hill-Burton program should give priority to those projects and facilities which propose to use innovative methods of delivering health care.

The provisions of title XIX that recipients will have "free choice" of vendor, should be interpreted as broadly as possible in order to promote use and reimbursement, under Medicaid, of new and effective organized forms of health-care delivery. Policy implementing the statute should be developed to require the States to take positive steps to arrange for reimbursement (preferably on a contract-payment basis) of neighborhood health centers, community mental health centers, migrant health projects, children and youth projects, prepaid group-practice plans, and other forms of organized health-care delivery.

With respect to State implementation of recommendations relating to use of earmarked Medicaid funds for development of resources, model development and others, the advice and consultation of the health-planning agencies should be sought and encouraged. Other aspects of financing, including participation requirements and reimbursement policy, should support planning activities.

To promote the early removal of State legal barriers, HEW should take steps to require that States permit prepaid group practices through a variety of approaches including regulations or legislation that would tie the receipt of grants that flow directly to State agencies such as Hill-Burton, 314(a) and (d), and Community Mental Health Center Construction to such a requirement; and other alternatives such as Federal charters for prepaid systems.

The Task Force strongly endorses the innovative approach of the Administration's Health Maintenance Organization proposal to provide an option for Medicare and Medicaid beneficiaries to elect to receive health services through a single organization that provides coordinated services financed through prepaid capitation.

The HMO proposal constitutes an important step toward possible long-range improvements in the organization and delivery of health services. Specific recommendations are made to improve and help flush out the concept.

HEW should actively program experiments for incentive reimbursement under Medicare and Medicaid, with emphasis on experiments in payment methods for physicians as the key generators of health services.

Reimbursement to providers of service under Medicare and Medicaid should be on a prospective instead of a retrospective basis.[1]

Fees and charges under the Medicare program also should not be recognized for benefit purposes when in excess of the 75th percentile of prevailing fees; and this limit should not be permitted to rise except in keeping with an index made up of pertinent wage and price increases.[1]

Title XIX should be amended to permit varying benefits for different population groups, or for different areas in a State if it is not feasible or possible to apply them uniformly elsewhere, e.g., States should be able to provide dental treatment to children 5–12 years of age as a first priority.

To guard against deterioration of quality of care while pursuing efficiency, various forms of professional review will be needed. These would evaluate the delivery of health care and help determine its adequacy or appropriateness.

Utilization review, including professional-review programs presently required under Medicare, Medicaid or related programs, should be given thorough study to evaluate effectiveness.

A standard definition of professional review should be adopted for all medical programs, and review requirements should be made uniform for comparable services covered by all Federal programs.

A legislative amendment is needed requiring uniform provisions and unified State standard-setting, certification, and consultation functions with respect to providers of service under both Medicaid and Medicare. (To the extent possible, also consistent with desired State flexibility to exceed Federal minimum standards. State-controlled licensure of

[1] H.R. 17550 passed by the House of Representatives on May 21, 1970, and now pending in the Senate.

health facilities and agencies should be integrated with these related functions.) The State agency with primary responsibility for health functions in the State should be responsible for all standards functions. Incentives, guidance and assistance should be provided to the States in bringing this about.[1]

Antiquated licensure laws contribute to manpower shortages and rising costs.

HEW should undertake a major, intensive study of State health personnel licensing laws and their influence on the utilization of manpower and make recommendations to the States for changes and revisions of licensure laws.

The Task Force supports the Administration's proposed "Health Cost Effectiveness Amendments." Particularly worthy of note are the coupling of reimbursement to areawide and institutional planning and the call for wider experimentation and demonstration among delivery systems.

Better management of health services

Controls and incentives will not be realized without more forceful leadership and better organization within the health field. The total job to be done will take the concerted efforts of both the public and private sectors. Many of the key considerations devolve upon HEW. It is here that primary leadership for the health system must be established and exercised.

"Fragmentation" of health service began when the doctor could no longer get everything he needed in his saddle-bags; it has been going on ever since, an inevitable result of the increasingly specialized technology. Fragmentation of services may be unavoidable at times and, of itself, is not always bad. What is bad is that, for lack of overall leadership, we have allowed organization and management to become fragmented, along with service, to the point where patients may be handed off from one institution or service or program to another in a kind of medical bucket line, with nobody in charge determining where the line begins, which way it goes, and where it ends. The result is that cost mounts and care suffers, not just for the poor but for the whole population. To find the beginning, chart the way and determine the end will require leadership not just of the parts but of the whole. The Task Force believes this leadership is the proper role of the Federal Government.

The Federal role in health has expanded markedly in recent years as the result of considerable legislation. Too many new programs are not co-ordinated well, nor integrated sufficiently with the old. HEW must be strengthened to assume a new role conceptually and to consolidate better the responsibilities assumed to date. The Task Force sees a "governing" role concentrating on goals and objectives, establishing policy, fashioning incentives, checks and balances, firmly protecting the public interest and evaluating results—presaging, perhaps, less extensive operation of programs with greater decentralization of operating responsibility.

A restructuring of HEW should have the following features: an Under Secretary for Health and Scientific Affairs (HSA); a career deputy with extensive background in health administration in a public setting; major executive agencies headed by assistant secretaries in: Scientific Affairs (NIH), Health Service Systems and Resources (HSMHA), Consumer Protection, Environmental Quality, and Management and Budget; a health systems analysis and planning staff, which would serve as the motive force for goal setting, analysis, planning and evaluation and may also serve as staff for a National Council of Health Advisors.

There is an urgent need to establish a National Council of Health Advisors responsible for assessing the Nation's health status and the status of the health system, for generating national health goals, and for outlining objectives for all Federal health programs.

The Task Force made the following recommendations:

Install, within the health component of HEW, an internal management system based on the "corporate management model" adapted to the peculiar requirements of a public-administration setting.

Provide the Under Secretary (HSA) with increased flexibility in the allocation of Federal resources, especially for the purposes of encouraging new institutional arrangements and the building of health-system capacity.

The operation of health-service activities should be decentralized through contractual agreements with public and private agencies.

The principal features of such agreements should be specification of desired outcomes rather than specific methods of operation, and evaluation and information systems that can assess performance in terms of output or results.

Good progress has been made recently in the revitalization, reorganization and staffing of the Medical Services Administration (the agency administering the Medicaid program at the Federal level), but substantial additional staffing and other administrative resources must be provided for this program. A redirection of effort is called for toward: strengthening the Federal Government's leadership role; employing state-of-the-art management techniques, including the development of relevant and cost-effective management control and information systems; and development of standards for States related to using Medicaid's purchasing power to increase accessibility of care to the needy and to improve the effectiveness of the care. A series of specific recommendations are made regarding implementation, primarily under management of Federal health activities, although there are others under effecting changes and improvements in the delivery of health care.

The Task Force viewed institutional areawide planning as a major arm of the new management. Currently, considerable confusion and overlap exists among planning efforts and agencies. Also, there are important gaps by section of the country. Results to date have been generally disappointing. The Task Force made several recommendations in this area that (1) clarify roles and functions of public and private planning agencies at the national, State and local levels; (2) call for more Federal support of State and local efforts; and (3) spell out the relations among the purchaser of care, the planning agencies, the constituent health institutions and the official sanctions to be exercised by Government.

Federal support was seen to include stronger leadership, greater financial assistance (manpower and program) and more extensive technical assistance.

Broader concept of health care

Although not concentrated in any given section, various references are made in the report to the need to promote and finance a broad range of facilities and services in order to forestall excessive preoccupation with and use of acute services. Currently, the health-care system is geared primarily to care for acute illness. This is a distortion of investment in both economic and human terms. A better balance, with heavy emphasis on primary care to prevent illness, and on rehabilitation to restore function, is needed and frequently cited. In discussing total health services and long-term care in particular, the report points up the necessity of supporting organizations that view health in the context of total life style and that can evaluate the effectiveness of various courses of action, including intervention and a broader orientation toward health generally, neither more responsible purchase of services nor better management will give health the status it deserves in an economy of scarcity.

CONSUMER PARTICIPATION

Not only do millions of consumers get care on a hit-or-miss basis or lack access to care except in medical crises, but virtually all consumers lack access to the decisionmaking machinery that can bring about change. Few institutions and programs include representatives of everyday users of their services on policymaking or governing boards, in spite of their nonprofit and presumably "community" character.

The result is that medical care is still too often delivered at the time and place, and in the way convenient to provider rather than consumer. Old patterns persist in the face of new demands—a basic cause of rising dissatisfaction with the health services.

A basic tenet of the Report is that greater consumer involvement in decisionmaking is required to overcome deficiencies in the health system with reasonable dispatch and to achieve better management of resources. Without substantial consumer input, health institutions can become excessively self-serving and in fact, tangential to even fundamental community health problems. Also, without consumer input, user identity with service can deteriorate; and inappropriate use can occur. Perhaps it should be added that, as in the management of other affairs, the consumer wants in—a valid reason for involvement in own right. There is no national means of providing the consumer the assistance he needs to

become a positive force for improving the Nation's health-care services, nor do the means now exist for bringing the consumer and provider together to work jointly for improvements.

A number of the recommendations bear on the problem of decisionmaking, involvement and education for this purpose.

> Any board or group set up to advise policymaking officials at any level of Government must provide for consumer representation to protect and present the interests and needs of the consumer. In addition, executive committees, subcommittees, and *ad hoc* committees of such board or groups should have a significant number of consumer representatives as members.
>
> Federal agencies involved in planning, delivering and purchasing health services must make provisions in budget for special orientation programs for new members of policymaking groups, including the consumer representatives on such groups.
>
> State and local agencies as well as non-governmental agencies involved in planning for, delivering and paying for health services should be required to make provisions for orientation and training of policymaking groups, with special emphasis on consumer representatives.

Still with focus on the consumer, the Task Force underscored the desirability of instructing users of services on their rights and benefits and how to best use available services.

> Programs of health education, provided they meet adequate standards set by the Federal Government, should be considered integral components of any health-care service and therefore included in the budget of such service. All agencies and institutions providing health services that receive Federal support must provide continuing programs of health education to their consumers.
>
> State Medicaid Programs should be required to undertake educational efforts designed to: improve recipients' use of the Medicaid program; improve the health of Medicaid recipients through preventive education; improve providers' use of the program, and provide for greater participation by provider and consumer in the planning, implementation, and evalution of the program.

Throughout its deliberations, the Task Force was deeply concerned about two issues that were given separate status at the end of the report, i.e., long-term care and long-term financing of health services. Each is complex and calls for extensive definition and debate. Our evaluation of title XIX and related programs has highpointed both.

LONG-TERM CARE

Nearly one out of three medical dollars is being spent on skilled nursing-home care, and these expenditures have been growing far beyond expectations. Major attention has been focused on the problems of medical care at one end of the spectrum and of income maintenance at the other. Long-term care is something less than one and something more than the other. Distortions have inevitably occurred, such as caring for essential personal needs in a medical environment (which, if unchecked, could bankrupt the health system), or returning persons with medical problems stabilized to an unaltered and unsuitable social environment. There are no easy answers, but the Task Force tried at least to point the way toward modest improvements.

Importantly, the Task Force thought that although classifying patients is sound, patients should not be summarily discharged from skilled nursing homes or other health facilities if alternate facilities are not available. Keeping a patient in a health facility when his needs for support services cannot be met elsewhere does not represent misuse; it represents a default on the part of the community to match services with needs. Investments in alternative services are the only humane way to solve the problem.

In regard to Medicaid, Medicare and public assistance programs, a number of specific recommendations are made:

> Skilled nursing home regulations under title XIX should require activities programing.
>
> Federal regulations for title XIX should require that all recipient-patients in nursing homes be visited by a public assistant agency staff member as needed, but not less often than quarterly.

The extended-care benefit should be redefined and revised to eliminate existing confusion and reduce administrative complexity.

The Department of Health, Education, and Welfare should consider:

That the Intermediate Care Facility remain generally defined as a zone of personal and residential service between the Skilled Nursing Home and the domiciliary institution to allow flexibility to the States for further definitions.

That the regulation on Intermediate Care Facilities be strengthened to require activity programming to provide a creative and constructive environment in these institutions.

That in relation to the Medicare program the Intermediate Care Facility be considered a long-term-care and not a medical-care institution, particularly that a stay in an Intermediate Care Facility should be considered to break a "spell of illness"; and after a stay for a sufficient period of time, the person is again eligible for hospital-insurance benefits.

That the benefits for Skilled Nursing Home and the Intermediate Care Facility Programs should be administered through a single administrative structure.

Decisionmaking on placement is a discriminating action. It is now sometimes performed by a health or welfare agency, or by the individual's physician, or several sources in concert. It requires an evaluation of the medical, nursing care and personal services needed by an individual, an appraisal of the financial resources available, a knowledge of the types and of the financial resources available, a knowledge of the types and quality of existing community services, and the ability to fashion congruence among these factors. Good information, a high degree of technical skill, and great sensitivity to individual, family and community needs are required. It is unreasonable to expect that each physician, hospital, or family faced with this decision can make an informed judgment when each must gather information through their own resources. The continual outcries of misuse of services and public money is additional incentive for an informed, community-wide process.

LONG-TERM FINANCING POLICIES

In evaluating title XIX, the Task Force concluded that the present financing arrangements for the existing and potentially eligible population are not adequate and that a new national policy for health-care financing is essential. Current arrangements, internally and as they relate to other financing systems, lack the structure and resources to impact sufficiently on problems of both access and productivity.

The Task Force thought that HEW should develop a policy position on this critical and comprehensive health-care issue as the basis of any legislative recommendations to be made in 1971 and as a measure against which to appraise proposals currently before the Congress, as well as those forthcoming. The issue is far too important to be debated hastily or conceived quickly in politically expedient terms.

During its tenure, the Task Force had neither the resources nor the time, in the light of its full agenda, to examine closely the full dimensions of the problem. Such an examination is needed. Major economic, fiscal and social policy implications are involved. However, the Task Force did examine current financing systems and their relationship to delivery of services, and developed observations that should be useful to those who follow. These are presented in two parts:

First, a list of central and necessary objectives against which, we believe, long-range financing proposals should be evaluated;

Second, a set of specific issues and questions, by which different proposals can be compared and appraised.

In an economy of scarcity, decisions regarding even such valued considerations as good health come hard. With this in mind, the Task Force believes strongly that a sizeable unmet need for health services is a disgrace and cannot be tolerated in an affluent society. We must be prepared as a Nation to spend more money so that all citizens have reasonable access to health care. This target will not be reached unless interim objectives are set, commitments are made, and the system is more aggressively managed. The Report points out ways to move ahead and identifies HEW as a critical leadership force. HEW's commitment is now the key to improving the health of the Nation in the decade ahead.

Appendix 9

REPORT OF PRESIDENT'S COUNCIL ON AGING

THE WHITE HOUSE,
Washington, January 29, 1971.

DEAR MR. CHAIRMAN: Complying with your recent request, enclosed is a report on the activities of the President's Council on Aging during 1970. Please let us know if you need additional information.

Sincerely,

JOHN B. MARTIN,
Special Assistant to the President for the Aging.

[Enclosure]

THE PRESIDENT'S COUNCIL ON AGING—1970

The President's Council on Aging is composed of the Secretary of Health, Education, and Welfare, its Chairman; the Secretaries of Agriculture, Commerce, Housing and Urban Development, Labor, Transportation, and the Treasury; the Chairman of the Civil Service Commission; the Administrator of Veterans Affairs; and the Director of the Office of Economic Opportunity. It is the principal mechanism established to assure interdepartmental cooperation on concerns of the Nation's elderly.

The department and agency heads who are members of the Council are represented in its work by the Executive Committee, which is composed of representatives of each department or agency on the Council. Usually, members of the Executive Committee are the individuals in each of the member departments and agencies who have most direct responsibility for its work in aging. The Chairman of the Executive Committee is the Commissioner on Aging.

During 1970, there was interdepartmental cooperation on two major endeavors in the field of aging which involved departments, agencies, and individuals who perform the work of the President's Council on Aging. Though formal meetings of the Council were not called, for practical purposes these activities should be attributed to the President's Council on Aging.

WHITE HOUSE CONFERENCE ON AGING

The first of these was the extensive interdepartmental cooperation in preparing for the White House Conference on Aging, scheduled for late November and early December, 1971. Departments and agencies represented on the President's Council on Aging assisted greatly in this effort by appointing personnel at the Assistant Secretary level to act as their liaison with Conference planners. This liaison personnel was most helpful in assigning personnel from their respective departments and agencies to advise and assist the technical committees which have been appointed for the Conference.

Many of the departments and agencies alerted either regional offices or field offices to the Conference needs and especially to the need of the State agencies on Aging for assistance. A number of them reproduced the plan for the Forums and distributed it with a request for personnel to assist the State agencies. For example, the Department of Agriculture alerted the nationwide network of county extension service agents who helped some of the States to organize, county by county. The Small Business Administration tied SCORE into the Forums. OEO made its CAP agencies available to involve the elderly poor.

President's Task Force on the Aging

The second major interdepartmental effort in Aging during 1970 wac activity in support of the President's Task Force on the Aging. This task force was composed of 14 outstanding authorities in the field of Aging, appointed by the President. Its chairman was Garson Meyer. The Task Force was charged to:

—Determine how best to achieve for the elderly the maximum security, dignity, and independence;
—Undertake a critical examination of problems faced by older people;
—Review what the public and private sectors are now doing to assist the aging;
—Appraise the effectiveness of present programs affecting the aging;
—Suggest how such programs might be improved;
—Determine what new actions might be taken now; and
—Recommend what might be done in the future.

The Task Force met a total of eleven days over a 3-month period from October 11, 1969, to January 11, 1970. Departments and agenccies represented on the President's Council on Aging were instrumental in providing technical assistance in preparation of material for review by the Task Force, and certain of their personnel were called upon to make presentations to the Task Force in areas where assistance was needed and requested.

The Task Force presented to the President on February 20, 1970, its report, "Toward a Brighter Future for the Elderly". A summary of its 24 recommendations appears in this report on Page 312. Since the Task Force report was issued, a joint interdepartmental review of its recommendations has been completed for White House use.

OTHER ACTIVITIES

Departments and agencies represented on the President's Council on Aging have also been of considerable help in preparing option papers and other information for White House use in responding to requests for a general review of the needs of older Americans, and the resources required to meet those needs.

CONCLUSION

In view of the high degree of interdepartmental cooperation forthcoming upon request, it was not thought necessary to call formal meetings of the President's Council on Aging during the year. It is contemplated that, upon the conclusion of the White House Conference on Aging, departments and agencies represented on the Council will be asked for assistance in implementing the recommendations of the Conference, in accordance with the President's wishes. To the degree necessary, liaison personnel assigned to assist with the Conference will be asked to continue to work with the Department of Health, Education, and Welfare and the Administration on Aging to develop ways and means of implementing the recommendations.

Appendix 10

COMMITTEE HEARINGS AND REPORTS

No asterisk indicates single copy available from committee and multiple copies available for purchase from U.S. Government Printing Office.

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.

With a request for printed copies of documents, please enclose self-addressed label for *each* item desired.

Action for the Aged and Aging, Report No. 128, March 1961.**

Action for the Aged and Aging, summary and recommendations of Report No. 128, 1961.**

Developments in Aging, 1959–63, Report No. 8, February 1963.**

Developments in Aging, 1963–64, Report No. 124, March 1965.**

Developments in Aging, 1965, Report No. 1073, March 15, 1966.**

Developments in Aging, 1966, Report No. 169, February 1967.***

Developments in Aging, 1967, Report No. 1098, April 1968 .(Cat. No. 90/2:s, $1.25)

Developments in Aging, 1968, Report No. 91–119, March 1969. (Cat. No. 91/1:119, $1.25)

Developments in Aging, 1969, Report No. 91–875, February 1970 (Cat. No. 91/2:S. Rpt. 875, $1.75)

Developments in Aging, 1970, Report No. ——, March 1971. (Cat. No. 92/1: S. Rpt. ——, $——)

Mental Illness Among Older Americans, committee print, September 8, 1961.**

New Population Facts on Older Americans, 1960, a staff report, May 24, 1961.**

Comparison of Health Insurance Proposals for Older Persons, 1961–62, committee print, May 10, 1962.**

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 3, 1961.**

The Farmer and the President's Health Program, May 17, 1962.**

Performance of the States, 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print report, June 15, 1962.**

State Action to Implement Medical Programs for the Aged, a staff report, June 8, 1961.**
Medical Assistance for the Aged, the Kerr-Mills Programs, 1960–63, committee print report, October 1963.**
Health and Economic Conditions of the American Aged, a chart book, June 1961.**
A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.**
Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 24, 1962.**
Statistics on Older People, Some Current Facts About the Nation's Older People, June 14, 1962.**
Basic Facts on the Health and Economic Status of Older Americans, June 2, 1961.**
Some Current Facts About the Nation's Older People, October 2, 1962.**
Housing for the Elderly, committee print report, August 31, 1962.**
The 1961 White House Conference on Aging, basic policy statements and recommendations, May 15, 1961.**
A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, June 1963.***
Blue Cross and Private Health Insurance Coverage of Older Americans, committee print report, July 1964.**
Increasing Employment Opportunities for the Elderly, committee print report, August 1964.
Services for Senior Citizens, Report No. 1542, September 1964.**
Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1963–64, a staff report, October 1964.**
Frauds and Deceptions Affecting the Elderly—Investigations, Findings and Recommendations: 1964, committee print, report, December 1964.***
Extending Private Pension Coverage, committee print report, June 1965.***
Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, a staff report, November 1965.**
War on Poverty as It Affects the Elderly, Report No. 1287, January 1966.***
Services to the Elderly on Public Assistance, committee print report, March, 1966.***
Health Insurance and Related Provisions of Public Law 89–97, the Social Security Amendments of 1965, committee print, October 1965.**
Needs for Services Revealed by Operation Medicare Alert, committee print report, October 1966.**
Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 31, 1966.**
Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print report, December 30, 1966.***
Reduction of Retirement Benefits Due to Social Security Increases, committee print report, August 21, 1967.***

Economics of Aging: Toward A Full Share in Abundance. A Working Paper, Committee Print, March 1969**[1]

Homeownership Aspects of the Economics of Aging, A Working Paper, Fact Sheet, July 1969.[1]

Health Aspects of the Economics of Aging. A Working Paper, Committee Print, July 1969 (Revised) (Cat. No. Y4:Ag4:H34/10, 25¢)**[1]

Social Security for the Aged: International Perspectives, A Working Paper, Committee Print, August 1969 (Cat. No. Y4:Ag4:Sol, 15¢)[1]

Older Americans in Rural Areas, A Working Paper, Fact Sheet, September, 1969[1]

Employment Aspects of the Economics of Aging, A Working Paper, Committee Print, December 1969 (Cat. No. Y4:Ag4:Em7/4, 15¢)**[1]

Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions, A Working Paper, Committee Print, January 1970 *[1]

Mental Health of the Elderly: Action Programs to Prevent, Reduce, or Improve Institutionalization, A Working Paper, Committee Print, May, 1971.[2]

The Stake of Today's Workers in Retirement Security: A Working Paper, Committee Print, April 1970.**[1]

Legal Problems Affecting Older Americans: A Working Paper, Committee Print, August 1970[1] (Cat. No. Y4:Ag4:011/2, 30¢).

Income Tax Overpayments by the Elderly, Report No. 91–1464, December 1970. (Cat No. 91/2: S. Rpt. 1464, 20¢).

Older Americans and Transportation: A Crisis in Mobility, Report No. 91–1520, December 1970 (Cat. No. 91/2: S. Rpt. 1520, 50¢).

Economics of Aging: Toward A Full Share in Abundance, Report No. 91–1548, December 31, 1970 (Cat. No. 91/2:S. 1548, $1.00).

Hearings

Housing problems of the elderly.**
- Part 1. Washington, D.C., August 1961.
- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

Subcommittee on Housing for the Elderly:**
- Part 1. Washington, D.C., December 11, 1963.
- Part 2. Los Angeles, Calif., January 9, 1964.
- Part 3. San Francisco, Calif., January 11, 1964.

Subcommittee on Involuntary Relocation of the Elderly:**
- 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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[1] Working paper incorporated into appendix of hearing.
[2] Price not determined at time of this printing.

Nursing homes:**
Part 1. Portland, Oreg., November 6, 1961.
Part 2. Walla Walla, Wash., November 10, 1961.
Part 3. Hartford, Conn., November 20, 1961.
Part 4. Boston, Mass., December 1, 1961.
Part 5. Minneapolis, Minn., December 4, 1961.
Part 6. Springfield, Mo., December 12, 1961.
Nursing homes and related long-term care services:
Part 1. Washington, D.C., May 5, 1964.
Part 2. Washington, D.C., May 6, 1964.
Part 3. Washington, D.C., May 7, 1964.
Long-term institutional care for the aged (Federal programs) : Washington, D.C., December 17–18, 1963.**
Conditions and problems in the Nation's nursing homes:**
Part 1. Indianapolis, Ind., February 11, 1965.
Part 2. Cleveland, Ohio, February 15, 1965.
Part 3. Los Angeles, Calif., February 17, 1965.
Part 4. Denver, Colo., February 23, 1965.
Part 5. New York, N.Y., August 2–3, 1965.
Part 6. Boston, Mass., August 9, 1965.
Part 7. Portland, Maine, August 13, 1965.
Blue Cross and other private health insurance:**
Part 1. Washington, D.C., April 27, 1964.
Part 2. Washington, D.C., April 28, 1964.
Part 3. Washington, D.C., April 29, 1964.
Deceptive and misleading practices in sale of health insurance: Washington, D.C., May 4, 1964.***
Frauds and quackery affecting the older citizen:**
Part 1. Washington, D.C., January 15, 1963.
Part 2. Washington, D.C, January 16, 1963.
Part 3. Washington, D.C., January 17, 1963.
Health frauds and quackery: (Cat. No. Y4.AG4:F86)
Part 1. San Francisco, Calif., January 13, 1964.
Part 2. Washington, D.C., March 9, 1964, 35 cents.
Part 3. Washington, D.C., March 10, 1964.
Part 4(a). Washington, D.C., April 6, 1964 (eye care).
Part 4(b) Washington, D.C., April 6, 1964 (eye care).
Interstate mail-order land sales:**
Part 1. Washington, D.C., May 18, 1964.
Part 2. Washington, D.C., May 19, 1964.
Part 3. Washington, D.C., May 20, 1964.
Preneed burial service: Washington, D.C., May 19, 1964.**
Retirement income of the aging:**
Part 1. Washington, D.C., July 1961.
Part 2. St. Petersburg, Fla., November 6, 1961.
Part 3. Port Charlotte, Fla., November 7, 1961.
Part 4. Sarasota, Fla., November 8, 1961.
Part 5. Springfield, Mass., November 29, 1961.
Part 6. St. Joseph, Mo., December 11, 1961.
Part 7. Hannibal, Mo., December 13, 1961.
Part 8. Cape Girardeau, Mo., December 15, 1961.
Part 9. Daytona Beach, Fla., February 14, 1962.
Part 10. Fort Lauderdale, Fla., February 15, 1962.

Increasing employment opportunities for the elderly :**
Part 1. Washington, D.C., December 19, 1963.
Part 2. Los Angeles, Calif., January 10, 1964.
Part 3. San Francisco, Calif., January 13, 1964.
Extending private pension coverage :**
Part 1. Washington, D.C., March 4, 1965.
Part 2. Washington, D.C., March 5–10, 1965.
Problems of the aging (Federal-State activities) :**
Part 1. Washington, D.C., August 1961.
Part 2. Trenton, N.J., October 23, 1961.
Part 3. Los Angeles, Calif., October 24, 1961.
Part 4. Las Vegas, Calif., October 25, 1961.
Part 5. Eugene, Oreg., November 8, 1961.
Part 6. Pocatello, Idaho, November 15, 1961.
Part 7. Boise, Idaho, November 15, 1961.
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.
Part 12. Hilo, Hawaii, December 1, 1961.
Part 13. Kansas City, Mo., December 6, 1961.
Federal, State, and community services for the elderly :**
Part 1. Washington, D.C., January 16, 1964.
Part 2. Boston, Mass., January 20, 1964.
Part 3. Providence, R.I., January 21, 1964.
Part 4. Saginaw, Mich., March 2, 1964.
Services to the elderly on public assistance: Washington, D.C., August 18–19, 1965.**
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 :
Part 1. Washington, D.C., January 17–18, 1967.
Part 2. Tampa, Fla., February 2–3, 1967.
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.**
Costs and Delivery of Health Services to Older Americans :***
Part 1. Washington, D.C., June 22–23, 1967.
Part 2. New York, N.Y., October 19, 1967.
Part 3. Los Angeles, Calif., October 16, 1968.
Retirement and the Individual :**
Part 1. Washington, D.C., June 7–8, 1967.
Part 2. Ann Arbor, Mich., July 26, 1967.
Reduction of Retirement Benefits Due to Social Security Increases: Washington, D.C., April 24–25, 1967.***
Rent Supplement Assistance to the Elderly: Washington, D.C., July 11, 1967.***

Long-Range Program and Research Needs in Aging and Related Fields: Washington, D.C. Decembeer 5–6, 1967. (Cat. No. Y4: Ag4:P94 Pt. 1)—$1.50.

Hearing Loss, Hearing Aids, and the Elderly: Washington, D.C., July 18 and 19, 1968.**

Adequacy of Services for Older Workers: Washington, D.C., July 24, 25, and 29, 1968. (Cat. No. Y4: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.
Part 2. Seattle, Wash., October 14, 1968.
Part 3. Ogden, Utah, October 24, 1968.
Part 4. Syracuse, N.Y., December 9, 1968.
Part 5. Atlanta, Ga., December 11, 1968.
Part 6. Boston, Mass., July 11, 1969.
Part 7. Washington, D.C., October 14–15, 1969.

Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans.**

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.
Part 5. Washington, D.C., November 20–21, 1969.

Economics of Aging: Toward a Full Share in Abundance: (Y4:Ag4: Ec7/Pts):

Part 1. Washington, D.C., April 29 & 30, 1969—$1.25.
Part 2. Ann Arbor, Michigan, Consumer Aspects, June 9, 1969—60¢.
Part. 3. Washington, D.C., Health Aspects, July 17 & 18, 1969**
Part 4. Washington, D.C., Homeownership Aspects, July 31 & August 1, 1969—55¢.
Part 5. Paramus, N.J., Central Suburban Area, August 14, 1969—40¢.
Part 6. Cape May, N.J., Retirement Community, August 15, 1969—30¢.
Part 7. Washington, D.C., International Aspects, August 25, 1969**.
Part 8. Washington, D.C., National Organizations, October 29, 1969**.
Part 9. Washington, D.C., Employment Aspects, December 18 and 19, 1969**.
Part 10A. Washington, D.C., Pension Aspects, February 17, 1970—60¢.
Part 10B. Washington, D.C., Pension Aspects, February 18, 1970—70¢.
Part 11. Washington, D.C., Concluding Hearing, May 4, 5, and 6, 1970—$1.00.

The Federal Role in Encouraging Preretirement Counseling and New Work Lifetime Patterns: Washington, D.C., July 25, 1969 (Cat. No. Y4:Ag4:P91)—35¢.

Trends in Long-Term Care: (Cat. No. Y4:Ag4:C18/Pts)

Part 1. Washington, D.C., July 30, 1969—60¢.
Part 2. St. Petersburg, Florida, January 9, 1970—50¢.

Part 3. Hartford, Connecticut, January 15, 1970—40¢.
Part 4. Washington, D.C, Marietta, Ohio fire, February 9, 1970—40¢.
Part 5. Washington, D.C., Marietta, Ohio fire, February 10, 1970—25¢.
Part 6. San Francisco, California, February 12, 1970—30¢.
Part 7. Salt Lake City, Utah, February 13, 1970—30¢.
Part 8. Washington, D.C., May 7, 1970—50¢.
Part 9. Washington, D.C., August 19, 1970 (Salmonella)—30¢.
Part 10. Washington, D.C, December 14, 1970 (Salmonella).[2]
Part 11. Washington, D.C., December 17, 1970.[2]

Older Americans in Rural Areas: (Cat. No. Y4:Ag4:R88/Pts.)
Part 1. Des Moines, Iowa, September 8, 1969—55¢.
Part 2. Majestic-Freeburn, Kentucky, September 12, 1969—15¢.
Part 3. Fleming, Kentucky, September 12, 1969—30¢.
Part 4. New Albany, Indiana, September 16, 1969—40¢.
Part 5. Greenwood, Mississippi, October 9, 1969—30¢.
Part 6. Little Rock, Arkansas, October 10, 1969—35¢.
Part 7. Emmett, Idaho, February 24, 1970—20¢.
Part 8. Boise, Idaho, February 24, 1970—30¢.
Part 9. Washington, D.C., May 26, 1970—30¢.
Part 10. Washington, D.C., June 2, 1970—25¢.
Part 11. Dogbone-Charleston, W. Va., October 27, 1970.[2]
Part 12. Wallace-Clarksburg, W. Va., October 28, 1970.[2]

Sources of Community Support for Federal Programs Serving Older Americans: (Cat. No. Y4:Ag4:OL1/3—Pts.)
Part 1. Ocean Grove, N.J., April 18, 1970—50¢.
Part 2. Washington, D.C., June 8-9, 1970—70¢.

Income Tax Overpayments by the Elderly, Washington, D.C., April 15, 1970 (Cat. No. Y4:Ag4:IN2) 40¢.

Legal Problems Affecting Older Americans, St. Louis, Mo., August 11, 1970 (Cat. No. Y4Ag4:L52/2) 50¢.

OTHER DOCUMENTS AVAILABLE

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, 1965.**
"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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[2] Price not determined at time of this printing.

"Amending the Older Americans Act of 1965—S. 268, S. 2120 and H.R. 11235", Public Law 91-69, June 19, 1969.**

"Older American Community Service Employment Acts—S. 3604"—Fall River, Mass., April 4, 1970; Washington, D.C., June 15–16, 1970—$1.00.

"Extended Care Services and Facilities for the Aging," Des Moines, Iowa, May 18, 1970—70¢.

Hearing held by Select Committee on Nutrition and Human Needs in cooperation with the Senate Special Committee on Aging, "Nutrition and the Aged, Washington, D.C., September 9–11, 1969.**

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