93D CONGRESS
1st Session

SENATE

REPORT
No. 93-147

DEVELOPMENTS IN AGING: 1972 AND JANUARY-MARCH 1973

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 251, MARCH 6, 1972

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

TOGETHER WITH

MINORITY VIEWS

MAY 10, 1973.—Ordered to be printed

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LETTER OF TRANSMITTAL

MAY 10, 1973.

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

DEAR MR. PRESIDENT: As required under Senate Resolution 251, dated March 6, 1972, I am submitting to you the annual report of the Senate Special Committee on Aging, "Developments in Aging 1972: and January–March 1973."

Publication has been delayed this year to allow some discussion of major new developments in the field of aging, including enactment of the Older Americans Comprehensive Services Amendments, now P.L. 93–29.

Senate Resolution 51, passed unanimously by the Senate on February 22, 1973, authorizes the committee to continue inquiries and evaluations of issues on aging. This includes not only those of age 65 and beyond but others who find that advancing years affect their lives in one way or another.

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 251, 92d CONGRESS, 2d SESSION

Resolved, That the Special Committee on Aging, established by Senate Resolution 33, Eighty-seventh Congress, agreed to on February 13, 1961, as amended and supplemented, is hereby extended through February 28, 1973.

SEC. 2. (a) The committee shall 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.

(b) 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. 3. (a) For purposes of this resolution, the committee is authorized from March 1, 1972, through February 28, 1973, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to hold hearings, (3) to sit and act at any time or place during the sessions, recesses, and adjournment periods of the Senate, (4) to require by subpena or otherwise the attendance of witnesses and the production of correspondence, books, papers, and documents, (5) to administer oaths, (6) to take testimony orally or by deposition, (7) to employ personnel, (8) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel, information, and facilities of any such department or agency, and (9) to procure the temporary services (not in excess of one year) or intermittent services of individual consultants, or organizations thereof, in the same manner and under the same conditions as a standing committee of the Senate may procure such services under section 202(i) of the Legislative Reorganization Act of 1946.

(b) The minority shall receive fair consideration in the appointment of staff personnel pursuant to this resolution. Such personnel assigned to the minority shall be accorded equitable treatment with respect to the fixing of salary rates, the assignment of facilities, and the accessibility of committee records.

SEC. 4. The expenses of the committee under this resolution shall not exceed $375,000, of which amount not to exceed $15,000 shall be available for the procurement of the services of individual consultants or organizations thereof.

SEC. 5. 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 February 28, 1973. The committee shall cease to exist at the close of business on February 28, 1973.*

SEC. 6. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee.

*S. Res. 51, agreed to Feb. 22, 1973, extended the committee through Feb. 28, 1974.

PREFACE

Older Americans can look upon 1972 as a year ranking behind only 1935, when Social Security was enacted, and 1965, when Medicare became law.

Major improvements in Social Security were made during the year, including a 20 percent across-the-board increase in benefits.

Important as that single action was, however, it should not overshadow other significant actions taken to provide economic security in retirement.

Accompanying the 20 percent provision was a long-awaited reform: cost-of-living adjustments to make Social Security benefits "inflation-proof" for the elderly. This automatic escalator will take effect in 1975.

Another historic reform due next year will be a Federal Supplemental Security Income program which will replace the present State-administered assistance programs for the aged, blind, and disabled. Here, at long last, will be a "floor" under the income of these Americans, and it will be provided through the Social Security Administration rather than local welfare offices.

As one who has sought just such a program, I am of course pleased. But I am also concerned because the new levels still fall far short of my goal to remove all older Americans from poverty.

On several additional fronts related to Social Security, the Congress made major advances. Widows' and widowers' benefits were increased. A new minimum monthly benefit was adopted, and a fairer way to compute men's benefits was established. The so-called "retirement test"—which dictates the amount of earnings that a person under 72 can have without a loss in Social Security benefits—was liberalized. (But I firmly believe that it is still too low and I will seek further improvement.)

Many other gains—including the authorization for a Nutrition for the Elderly program—are described in the pages of this report, and the Senate Committee on Aging can take some satisfaction from the role it played in helping them along.

This satisfaction, however, is tempered by certain realizations. The Social Security system, improved as it may have been in 1972, is far from perfect. Health costs, for example, are still of major concern to the elderly, despite the essential help provided by Medicare. Of utmost priority is the need to provide coverage for certain out-of-hospital prescription drugs. Deductibles and coinsurance, which have gone up steadily since Medicare began, should be re-examined and reduced, instead of going up still further, as proposed by the Administration.[1]

A more deep-rooted question about Social Security is raised by those who say that the payroll tax which almost completely finances the system is especially unfair to low-income wage earners. Although the

[1] See chapter III for additional discussion of health issues, including details of an Administration plan to increase "cost-sharing" by Medicare participants.

benefits they eventually may receive are proportionately higher than those received by persons with higher pay, the strain of the payroll tax is severe. To examine this and other questions, I have begun hearings on "Future Directions in Social Security." Testimony will be taken throughout the remainder of 1973, in what I expect to be a far-reaching, objective inquiry.

Another issue of special concern is the present uncertainty about legislation to continue and broaden the Older Americans Act of 1965. The Congress approved and sent to the President last year a bill which would have made major improvements in the original legislation. A pocket veto, however, undid the congressional action; and threats of a new veto have been made in 1973 despite congressional efforts to meet several of the President's objections to the bill.

Housing, too, is enveloped in uncertainty. A moratorium and other restrictive actions have hit hard at plans to provide shelter for the elderly in many communities of the Nation. As this report indicates, public and private sponsors of projects specially designed for older Americans have grave reservations about present Administration policies.

Additional questions about other Administration decisions related to aging are raised in other pages of the following report. Many of these questions are related to proposals made in the Administration's budget request of early 1973.

I, too, have questions about the reasoning behind many of the decisions expressed in the budget request. For example, the budget still calls for high military expenditures, despite the end of the ground war for the United States in Viet Nam. Our Nation is called upon to expend huge sums for foreign aid, despite a rapidly changing world situation which has removed the need for so much unilateral assistance by this Nation. The Administration calls the Congress spendthrift, failing to acknowledge that Congress reduced every one of the four Nixon budgets proposed during his first four years.

Another disturbing question arises from the Administration's apparent unwillingness to declare national goals for older Americans. Major recommendations of the White House Conference of 1971 are ignored or, in effect, challenged. For example, Administration spokesmen defend the Medicare "cost-sharing" proposals by saying that the elderly can afford to pay more for health care because their Social Security was increased last year. In other words, the Administration—which opposed the 1972 20-percent increase—apparently believes that the elderly should be kept at a fixed level of deprivation. If a gain is made on one front, it should be undone on another. My own view is that the progress made last year was historic, but it was far from adequate. Economic security of the elderly still stands in need of improvement, not erosion. Perhaps the most urgently needed action is relief from property tax payments by those who pay more than a reasonable percentage of their income for that tax or for rent. I have introduced a bill for that purpose, and I am happy to see that the President recently reaffirmed his pledge to reduce the property tax burden on the elderly. He has not, however, provided details; and he has not included funds for such a purpose in his budget for Fiscal Year 1974.

One more comment should be made in this brief preface about the President's budget requests and other actions he has taken to keep Federal costs within his $268.7 billion limit.

I, too, believe that almost $269 billion is high enough—more than high enough—for our national budget. I believe that the Congress should—and will—keep spending at or below that level. But I also believe that Congress has a responsibility to make certain that actions taken in the name of economy actually do result in savings and do not result, ultimately, in higher costs.

For example, recent curtailments have threatened home care programs in many States. Such programs help those persons, including many older persons, who are ill, but not ill enough to need around-the-clock care at an institution. But if their home care is eliminated, many will be transferred to hospitals or nursing homes simply because there is no other place for them. They will receive the most expensive kind of care simply because more appropriate levels of care are not available.

Budgetary discipline does not *have* to mean neglect of people and wholesale abandonment of those programs that do make sense. It is the duty of Congress to investigate every proposal made by the Administration for curtailment, to concur with those that are based upon adequate information and concern about people now served by those programs, and to resist cutbacks that in the long run will cost more than they would save. Furthermore, Congress should offer its own alternatives and insist upon them when they are right.

The clash between Congress and the Administration on budgetary priorities need not be disastrous. It can lead to constructive action if the Congress and the public insist upon good performance by their Federal Government. I will do all in my power to assure that the Senate Special Committee on Aging plays an appropriate part in that effort.

FRANK CHURCH,
Chairman, Special Committee on Aging.

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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 or every twenty-fifth American. Today, some 21 million older individuals make up 10 percent of the total population—every tenth American. The largest concentrations of older persons—11 percent or more of a State's total population—occur in 12 States in the agricultural midwest, in New England, and in Florida. New York, California, Pennsylvania, and Illinois each have more than a million older people with Ohio, Texas, and Florida very close behind. By 1985, when the older population in the Nation will have passed the 25 million mark, California and New York will each have more than 2 million persons aged 65+, and 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 is still growing. Between 1960 and 1970, older Americans increased in number by 21 percent as compared with 18 percent for the under-65 population. Greatest percentage growth (a third or more) occurred in Arizona, Florida, Nevada, Hawaii, and New Mexico. Florida, with considerable immigration, had the highest proportion of older people in 1970, 14.5 percent of its total population, while New York had the largest number of older people, almost 2 million.

ON "TURNOVER". The older population is not a homogeneous group nor is it static. Every day approximately 4 thousand Americans celebrate their 65th birthday. Every day approximately 3 thousand persons aged 65+ die. The net increase is about a thousand a day or over 350,000 a year but the "newcomers" are quite different from those already 65+ and worlds apart from those already centenarians who were born during or shortly after the Civil War.

ON AGE. Most older Americans are under 75 (60 percent); half are just under 73; about a third are under 70. Between 1960 and 1970, the population aged 65 through 74 increased 13 percent, the population aged 75+ increased 37 percent. More than 1.5 million Americans are 85 years of age 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

[1] Prepared by Herman B. Brotman, Director, Division of Data Analysis, Administration on Aging, HEW, February 1973.

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conditions still manage by themselves. Older individuals are subject to more disability, see physicians more often, and have more and longer hospital stays than do younger persons.

In FY 1971, per capita health care costs for older Americans came to $861, almost three and a half times the amount spent for younger persons. $410 went for hospital care, $144 for physician services, $34 for other professional services, $87 for drugs, $151 for nursing home care, and $36 for miscellaneous items. Older people represent 10 percent of the population but account for 27 percent of the health care expenditures. Of the health care costs for older persons, $583 of the $861 total or 68 percent came from public program resources.

ON PERSONAL INCOME. Older persons have less than half the income of their younger counterparts. In 1971, half of the families headed by an older person had incomes of less than $5,453 and the median income of older persons living alone or with nonrelatives was $2,199. Some 4.3 million or about 22 percent of the elderly were living in households with incomes below the official poverty threshold; this was an improvement over the 1970 figure of 4.7 million and results from the increase in social security benefits. Women and minority aged are over-represented among the aged poor. Many of the aged poor became poor after reaching old age because of the cut in income brought by retirement from the labor force.

ON EXPENDITURES FOR CONSUMPTION. Older Americans spend proportionately more of their income on food, shelter, and medical care in a pattern generally similar to that of other low income groups.

ON LIFE EXPECTANCY. At birth—70.4 years; 66.8 for men but 7½ years longer or 74.3 for women. At age 65, 14.8 years; 13.0 for men, 16.5 for women.

ON SEX. Most older persons are women—over 12 million as compared to over 8 million men. Between ages 65 and 74, there are 129 women per 100 men; after 75, there are 156. The average for the total 65+ group is 139 women per 100 men.

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 men, almost 40 percent have under-65 wives. In a recent year, an estimated 16 thousand older women and 35 thousand older men get married. Both bride and groom were 65+ in about 14 thousand of these marriages, the remaining 2 thousand older brides and 22 thousand older grooms took 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 family settings; about a quarter live alone or with nonrelatives. Only one in 20 lives in an institution. About two-thirds of the older men live in families that include their spouse

but only one-third of the older women live in families that include their spouse. About a quarter of older women head their own households or live in the home of a relative and a third live alone. Three times as many older women live alone or with nonrelatives as do older men.

ON PLACE OF RESIDENCE. A somewhat smaller proportion of older persons than of younger persons live in metropolitan areas (61 vs 65 percent). Within the metropolitan areas, however, most older people live in the central City while most under-65 persons live in the suburbs. (55 and 56 percent respectively)

ON VOTING. In the 1972 elections, older people formed about 15 percent of the voting age population and of the persons who actually voted. About 63 percent of the older population voted, the same as the average for all ages. The greatest voter turnout was in the 45 to 64 ages (71 percent), the lowest in the under-21 group (48 percent).

ON MOBILITY. In the year ending March 1971, 8.7 percent (1.7 million) of all older people moved from one residence to another. Six percent moved to another residence in the same county, 1.3 percent moved to a different county in the same State, and only 1.4 percent moved across a State line.

ON EMPLOYMENT. In 1972, about 16 percent of the persons aged 65+ were in the labor force with concentrations in three low earnings categories: part time, agriculture, and self employment. Unemployment rates were low, due partly to the fact that older persons stop seeking jobs and leave the labor market. For those remaining in the labor force and counted as unemployed, the average length of unemployment was greater than for younger groups.

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May 10, 1973.—Ordered to be printed

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

REPORT

TOGETHER WITH MINORITY VIEWS

[Pursuant to S. Res. 251, 92d Cong.]

INTRODUCTION

GAINS AND THREATENED LOSSES SINCE THE WHITE HOUSE CONFERENCE ON AGING

Older Americans had reason for both satisfaction and misgivings during the first 16 months following the White House Conference on Aging.[1]

Among the reasons for satisfaction:

- The White House Conference on Aging recommendations—despite rejection by certain Administration actions—have not been denounced or forgotten by the Executive Branch. A Post White House Conference Board is still at work, preparing a report on total Administration response to the Conference.
- In terms of congressional action on retirement income, 1972 was a year of remarkable accomplishment. A 20-percent across-the-board increase in Social Security benefits was enacted. A Supplemental Security Income program—replacing the much-criticized Old Age Assistance program—was passed and will take effect next January. Additional improvements in Social Security, including higher widows' benefits, became law.
- Major advances were also made in other retirement programs, including a 20-percent increase in Railroad Retirement annuities and establishment of a new formula for the veterans' pension

[1] The Conference began on November 28, 1971, and ended on December 2. For official details on the structure, objectives, and recommendations of the Conference, see pp. 276-288 of *Developments in Aging: 1971 and January-March 1972*. For additional information about the conference and for the full text of its recommendations, see *1971 White House Conference on Aging: Toward a National Policy on Aging, Volumes I and II* (For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, $6.75 per two volume set.)

program to preclude [2] the loss of aggregate income in the future when a pensioner receives an increase in income from any other source.

- The Labor and Public Welfare Committee reported out legislation proposing major reforms for the private pension system, including provisions for vesting, minimum funding requirements, pension plan reinsurance, portability of pension credits, and strengthened fiduciary standards for pension plan administrators.
- Two long sought manpower proposals—the Older American Community Service Employment Act and the Middle-Aged and Older Workers Training Act—were passed by the Congress to maximize job opportunities for unemployed or underemployed mature workers.
- Congress has twice passed legislation that would remodel and broaden the Older Americans Act of 1965—an action sought by the White House Conference.*
- The Senate passed a housing bill which would have implemented major White House Conference recommendations in this area.
- A Nutrition for the Elderly Program was enacted early in the year after the Administration reversed position and withdrew its opposition. This was another important goal of the White House Conference.*
- The President's Special Assistant for Nursing Homes continued her work during the year and took several progressive steps forward.[3]—Medicare was broadened to include coverage for the disabled; home health care costs to the patient were reduced; and coverage was extended to persons needing kidney transplantation or dialysis.
- H.R. 1 (now P.L. 92–603) also included a provision intended to end the "retroactive denial" problem—the decision not to pay for health care already given under Medicare.
- New disclosure requirements for ownership of intermediate care facilities under Medicaid were required.
- Congress passed a Research on Aging bill which would have established a new Institute on Aging at the National Institutes of Health.
- Higher funding levels were approved by Congress for the Age Discrimination in Employment Act and aging research and training activities at the National Institute of Child Health and Human Development.
- A Presidential Message on Aging was delivered on March 23, 1972,[4] and several commitments were made, including action on property tax relief.
- The President's budget request, as announced in January 1973, proposed widespread cutbacks in other programs but kept the Administration on Aging request for service programs at the same level as last year, $100 million. He also recommended $100 million for the nutrition program.

However impressive the list of accomplishments has been since the White House Conference, it must be balanced by a report on other developments.

[2] This protection would preclude the loss of aggregate income provided the pensioner's income does not exceed the maximum income limitation.
[3] For a report by Dr. Marie Callender on her program, see Appendix One, p. 219.
[4] For full text, see pp. 283–307 of annual report cited in footnote 1.
*On May 3, 1973, President Nixon signed P.L. 93–29, the Older Americans Comprehensive Service Amendments (formerly S. 50).

- The Administration opposed the 20 percent Social Security increase and apparently still has misgivings about it.[5]
- Presidential vetoes were handed down against the proposed Older Americans Comprehensive Service Amendments in 1972, and another veto in 1972 had been directed at the Research on Aging Act.
- The veto of the Older Americans Comprehensive Services Amendments also prevented the new manpower provisions for older workers from being launched. The threat of a veto caused the Congress to delete the provisions relating to the training of middle-aged and older workers.*
- Housing for the elderly proposals may have advanced in the Senate, but the House of Representatives was unable to agree upon a bill in 1972. Prospects for housing legislation in 1973 were uncertain, because of Administration intentions to replace many existing programs with a new community development revenue-sharing bill.
- Funding for the nutrition program was delayed in 1972 because of two vetoes of a Department of Labor-HEW appropriations bill. (However, moves were afoot in April 1973 to have funding included in a supplemental appropriations bill).
- Despite improvements in Medicare and Medicaid under H.R. 1 (P.L. 92-603), several steps which could prove to be regressive were taken (See Chapters III and IV for details).
- The President's commitment to property tax relief was voiced again in 1973, but funds for this purpose were not included in his budget request.
- The President's budget proposals of 1973, while providing the same level of funding for the Administration on Aging as in the previous year, fell far short of the authorizations that Congress had voted in the Older Americans Comprehensive Services Amendments of 1972 and again in 1973.
- Overall, the President's budget requests in January 1973 proved alarming in many proposals affecting older Americans. Congressional opposition welled up immediately to the proposed increases in the costs of Medicare to the ill elderly participants who seek health care under that program (see Chapter III for details). The Medicare issue may have been the most visible cause of concern, but there were others. (See Chapter I for details).
- In addition, Federal funding of social services for the elderly (and other age groups) would be sharply curtailed under a ceiling and new eligibility requirements voted by Congress last year. This curtailment would be even more severe under regulations issued by HEW on February 16. (See Chapter VII for details).

FINDINGS AND RECOMMENDATIONS

The Senate Committee on Aging, reviewing the progress since the White House Conference on Aging, finds that bipartisan interest and support in the Congress—together with some initiatives by the Administration—have resulted in far-reaching accomplishments.

[5] In fact, recent Social Security increases have been used by the Administration as an argument for increasing costs paid by Medicare participants. Health, Education, and Welfare Secretary Caspar Weinberger, discussing proposed "cost-sharing" under Medicare, cited Social Security increases in testimony before the Health Subcommittee, U.S. Senate Committee on Aging on March 5, 1973, and said: "It is therefore now feasible to make greater, although still quite limited, use of cost-sharing provisions in order to improve the design of the program."

*However, the Title IX, Older Worker Community Service Employment program was included in P.L. 93-29, as signed by the President. See footnote * for further discussion.

However, the 1973 budget requests have laid down several important challenges that threaten to undo important components of progress or potential progress. It is to be hoped that the bipartisan congressional objectivity which in the past has achieved so much on behalf of older Americans will continue, and that no deliberations over programs for older Americans will be subjected to dogmatic belittlement or inadequate examination. If programs are to be suspended or curtailed, such action should be based upon factual reporting, good judgment, and concern about those persons served by the programs under discussion.

Agreeing on the need for review of Federal programs on aging, the Committee on Aging will make its own appraisals and will join with units of standing committees whenever possible for legislative review. Hearings have already begun on "Future Directions in Social Security" and "Barriers to Health Care for Older Americans." A report, *The Rise and Threatened Fall of Service Programs for the Elderly,* was issued in March and discusses immediate and long-range issues related to services. An updated report on home health care is about to be issued. Others are contemplated. Judgements about future Federal actions on aging must be made on the basis of adequate data, and the committee will do all in its power to help provide that information.

The committee believes that all Americans should—when reviewing the Social Security gains of recent years—be aware of two major facts (1) despite the increases in monthly payments, the elderly are still at an extreme disadvantage in today's market place, and 3.1 million still live in poverty and (2) across-the-board Social Security increases benefit not only the elderly, but also those younger Americans who receive protection under disability and survivors provisions.

The committee makes specific action proposals at the end of each chapter in this report, but it must point out in this introductory statement that the income status of older Americans cannot realistically be evaluated unless two major drains on that income are recognized and understood.

The first major drain is still the high cost of health care for older Americans, even with the valuable and essential Medicare coverage. *One measure of the problem is the fact, reported in chapter III of this report, that out-of-pocket health care costs for the elderly are actually $42 more today than they were the year before Medicare went into effect.*

The second major drain is, fortunately, receiving more and more attention. It is the property tax, which takes a disproportionate share of retirement income. The Administration and the Congress have expressed concern about this issue, and action is overdue.

In addition, the committee again urges that a proposal to call "Mini-White House Conferences on Aging" be enacted at an early date. Under this proposal,[6] small convocations of experts would be called three or four times before 1981 to evaluate progress made since the 1971 conference and to make technical and policy proposals to speed implementation of the 1971 conference recommendations.

[6] On Mar. 3, 1972, Senator Church introduced S.J. Res. 212 which would authorize the President to call for periodic conferences on aging (every 2 years) to assess the effectiveness of the Nation's efforts in implementing the proposals advanced at the 1971 White House Conference on Aging.

PART ONE

CHAPTER I

THE 1974 BUDGET PROPOSALS AND AGING

Major reductions in programs to serve older Americans are proposed in the budget submitted by President Nixon to the Congress on January 29.

The $268.7 billion Nixon budget covers fiscal year 1974, which begins on July 1, 1973, and ends on June 30, 1974. In his message, the President said that between 1969 and 1974, outlays for Federal human resources had increased by 97 percent, while total budget outlays have grown by only 46 percent. Furthermore, he said:

> . . . human resources spending now accounts for close to half the total budget dollar compared with just over one-third of the total at the time that I took office.

I. THE PROPOSED CUTBACKS

Nevertheless, the fiscal year 1974 budget proposed steps that would reduce Federal outlays for the elderly of this Nation.

Among them:

"Cost-Sharing" in Medicare

Medicare participants now pay the first $72 of their hospital bill and nothing else until after the 60th day. The budget proposal envisions their paying the actual hospital room and board charges for the first day plus 10 percent of all subsequent hospital charges, including tests. Approximately 5 million Medicare beneficiaries will be hospitalized during the next fiscal year; and the great majority of them would pay considerably higher bills than is now the case.

In addition, the Administration proposes to (1) raise the deductible for doctor bills under Part B from $60 to $85 and (2) increase patients' coinsurance costs from 20 to 25 percent of the balance. Nearly 11.6 million Medicare beneficiaries are expected to require reimbursable physician and other qualifying services during fiscal year 1974, and they, too, would have significant increases in personal costs.

This "cost-sharing"—as Secretary of HEW Caspar Weinberger, describes it—would reduce the budget by about $500 million [1] a year; but it has already run into intense criticism in the Congress and elsewhere. In addition, critics have said that the cost to the elderly and disabled will be more like $1.2 billion the first year.

Congressional action would be required before such "cost-sharing" could take place.

(For additional details, including a summary of testimony by HEW Secretary Caspar Weinberger, see Chapter III.)

[1] Testimony by Caspar Weinberger, hearings on "Barriers to Health Care for Older Americans"; Subcommittee on Health of the Elderly of the Senate Special Committee on Aging; March 5, 1973; (hearings not yet in print).

Older Americans Act Funding Cut Back

For fiscal 1974 the President requested $202.6 million for the Title III (Area Planning and Services, Model Projects, and State Administration) programs, Title IV Research, Title V Training, and Title VII Nutrition program. This amount, however, was $10 million below the revised budget estimate of $212.6 million for fiscal 1973.

Proposed appropriations for research and training would be cut back sharply. No funding at all was requested for training, an item which the Administration had allocated $8 million the year before.

(See Chapter VI for additional details on the Older Americans Act.)

Services for the Elderly

The budget request for social services available under several titles of the Social Security law is apparently based upon a $1.7 billion level that would have been implemented under terms of regulations issued on February 16, 1973. A $2.5 billion ceiling on the Social Security services (see Chapter VII for more discussion) had been set by Congress last October. Such services are not limited to the elderly, but many States have already made wide use of 75–25 Federal matching funds to devise programs for older persons.

Funding for Other Major Programs

On other fronts the fiscal 1974 budget represented a cutback—or at best a holding action—for many programs serving the elderly. Funding for ACTION's principal aging programs (Foster Grandparents and RSVP) was identical to the fiscal 1973 budget estimate of $40 million. But this is still less than one-half of the authorized funding level ($82 million) approved by Congress in the Older Americans Comprehensive Services Amendments for Foster Grandparents and RSVP.

A $1 million reduction for aging research and training activities at the National Institute of Child Health and Human Development was also proposed in the Administration's budget. The fiscal 1974 budget message called for an appropriation of $11.838 million, compared with $12.998 million in the budget estimate for fiscal 1973.

Additionally, a $300 million cutback (from $2.5 billion in fiscal 1973 to $2.2 billion requested for fiscal 1974) in Federal funding for the Food Stamp program was recommended. Federal outlays for manpower programs were also reduced sharply, from about $1.7 billion in 1972 to approximately $1.3 billion for fiscal 1974. (For further discussion of funding for manpower program, see Chapter VIII.)

And one of the most potentially far-reaching budgetary developments was the suspension (effective January 5, 1973) of new housing commitments for public housing, rent supplements, Section 235 homeownership, and Section 236 rental assistance (For further discussion, see Chapter V.)

II. THE PRESIDENT'S PROGRAM ON AGING

President Nixon's Budget Message promised "further improvement in the welfare of the aging."

Additional word on Administration intentions for older Americans was provided on March 1 in the President's Message on Human Resources.

To deal with "a major item of unfinished business" on behalf of the 13.2 million 65+ persons who own their own homes, the President said he will submit "recommendations for alleviating the often crushing burdens which property taxes place upon many older Americans."

No specific authorization for such a purpose, however, is listed in the budget. Presumably, any such relief would take place after fiscal year 1974.

As his final item, the President said he would ask the cooperation of Congress in passing his budget request of $200 million to fund programs of the Administration on Aging. The President said that this funding level would be more than four times that appropriated for AoA during fiscal year 1972. Nevertheless, it is considerably below the levels sought by Congress in fiscal 1974 for the Older Americans Comprehensive Services Amendments.

III. THE QUESTION OF BUDGET OUTLAYS—"THE UNIFIED BUDGET"

President Nixon asserted in his Message on Aging last March that "overall Federal spending for the elderly in fiscal 1973 will be $50 billion."

However, about $48.5 billion—or nearly 98 percent of the socalled outlay for the aged—is for Social Security, retirement, income supplement, and health programs.[2] These outlays are derived primarily from payroll contributions made to trust funds, and only a very small proportion comes from general revenues. Nevertheless, under the "unified budget" procedures adopted in 1968, such trust funds have been included in the total budget. Supporters of the "unified budget" argue that, in the long run, the payroll contributions made to Social Security, Medicare, and other programs are major taxes which must be included in the budgetmakers' considerations when they assess the total tax load upon the citizens of this Nation.

As one spokesman[3] put it:

> There is no basis for pretending that a part of these taxes don't count. They do count, in every sense. They have to be withheld from the same paycheck as income taxes, and paid into the same Treasury. It is certainly not possible to establish intelligent income tax policy while pretending that employment taxes do not exist.

Nevertheless, questions remain about the practice of including trust funds in the total budget.

A classic statement on this point was made in the report of the 1971 Social Security Advisory Council.[4] The Advisory Council, which was chaired by Arthur Flemming (now the President's Special Consultant on Aging), emphasized:

> Policy decisions affecting the social security program should be based on the objectives of the program rather than on any effect that such decisions might have on the Federal

[2] See pp. 5–7, "*Developments in Aging: 1971 and January–March 1972*", annual report of the Senate Specia Committee on Aging, May 5, 1972. See pp. 283–308 for text of President's Message.

[3] Robert C. Moot, Assistant Secretary of Defense, in testimony on "National Priorities—The Next Five Years" (p. 190) before the Subcommittee on Priorities and Economy in Government of the Joint Economic Committee.

[4] "Reports of the 1971 Advisory Council on Social Security", H. Doc. 92-80, April 5, 1971.

> budget. The operations of the social security and other Federal trust funds should continue to be identified as such and separated from the general operations of the Government.[5]

The Advisory Council pointed out that any substantial imbalance between income and outgo in trust funds can affect the surplus or deficit position of the budget. Then the Advisory Council warned:

> This situation can create pressure to recommend or to defer changes in the social security law, not to further the objectives of the social security program, but rather to attain desired budget goals.[6]

Mr. William Hutton, Executive Director of the National Council of Senior Citizens, has asserted that trust funds can be used to create a "paper surplus" to improve the overall appearance of the unified budget. His case in point was the 20 percent Social Security increase enacted in 1972, which the Administration had opposed. He explained:

> If Congress had not given our elderly that 20 percent boost, the Administration would have been able to utilize the resulting additional surplus of $6 billion in the Trust Fund to pare down some of the deficits caused by overspending in Vietnam. That's what the Administration was unhappy about. That's why President Nixon opposed the 20 percent increase.[7]

FINDINGS AND RECOMMENDATIONS

Claims about so-called Federal "expenditures" for the elderly oftentimes result in very misleading conclusions. A major reason: *Federal* outlays constitute the bulk of all public expenditures on behalf of aged and aging Americans. On the other hand, public outlays for younger Americans are provided primarily by *State* and *local* governments, not the Federal Government. For example, more than three-fourths—or about $53 billion—of public spending for education is provided by State and local governments.[8]

Well over 90 percent of Federal outlays for the aged are for Social Security, retirement, income supplement, and health programs. And, the overwhelming proportion of these outlays are from trust funds, to which the elderly contributed during their working years. In no way should this be construed as the Federal Government giving the aged "something extra." They have *earned* this protection during their working years under social insurance programs, such as Social Security.

A close analysis of "discretionary" types pending (such as housing programs for the elderly or manpower efforts for older workers)—as opposed to trust fund outlays—will reveal that aged Americans have not been given preferential treatment. Quite to the contrary, they have oftentimes been overlooked or ignored by Federal programs.

[5] Page 63 of report cited in footnote 4.
[6] Page 64 of report cited in footnote 4.
[7] Congressional Record, March 22, 1973, p. S. 5470.
[8] Digest of Educational Statistics 1971.

Moreover, many of the so-called outlays for older Americans actually include younger Americans as well. For instance, more than 7 million Social Security beneficiaries are persons under age 62 who receive survivor and disability benefits. This represents more than one-fourth of all beneficiaries under Social Security.

Far from being a preferentially treated group, the aged are still struggling against some very real and formidable obstacles: Low income in retirement, inflation, rising property taxes, a crisis in mobility, and intensifying health care costs, just to name a few.

CHAPTER II

PROGRESS, PROBLEMS IN RETIREMENT INCOME

Older Americans had more dollars to spend at the beginning of 1973 than they had at the beginning of 1972.

They had won a 20-percent increase in across-the-board Social Security payments.

They had won other major improvements later in the year when a pared-down version of H.R. 1[1] was finally passed.

One H.R. 1 provision has still to take effect: on January 1, 1974, the long-awaited "Federalization" of Old Age Assistance will become operative. Under a new Supplemental Security Income program, a floor will finally be placed under the income of all older Americans.

A year later, still another historic step will be taken: to make Social Security benefits "inflation-proof" a cost-of-living adjustment mechanism will go into effect.

These steps forward, however, were voted into law at a time when the cost-of-living—particularly for those items most needed by the elderly—continue to rise at appalling speed.

In addition, even the remarkable legislative victories of 1972 failed in one vital measure of this Nation's effort to promote retirement security—3.1 million older Americans still live in poverty. Many are also hard-hit by the bite taken from their income by the property tax.

To explore the work that still remains—and to consider criticisms of the payroll tax and other features of the present system—the Senate Special Committee has begun hearings on "Future Directions in Social Security."

I. THE DIMENSIONS OF THE 1972 VICTORIES

Social Security Commissioner Robert Ball[2] said at the end of 1972:

> Changes in Social Security enacted in 1972 have so significantly improved and modernized our Social Security program that we can say in truth that we have a *new* Social Security program—one that provides a new level of security to working people of all ages and to their families.

[1] H.R. 1—the Social Security Amendments of 1972—was signed into law (Public Law 92-603) on October 30. The new law will provide $2.3 billion in added cash benefits for calendar year 1974. Moreover, Medicare benefits (under Part A Hospital Insurance and Part B Supplementary Medical Insurance) will be increased by more than $2 billion in 1974.

[2] Commissioner Robert Ball headed the Social Security Administration from 1962 until March 17, 1973. He is now a scholar in residence at the Institute of Medicine which is associated with the National Academy of Sciences. Mr. Ball will engage in an appraisal of the Social Security and Medicare programs and alternative approaches to their future extensions and modifications.

Commissioner Ball's estimate of the situation was based upon these actions by Congress:

A. 72 Percent Social Security Increase in Last 5 Years

Social Security benefits have increased by 71.6 percent [3] in the last 5 years—an unparalleled achievement in the history of the Social Security program. On an individual basis, the four across-the-board benefit raises improved monthly payments by the following amounts:

Beneficiary	Average monthly payments rounded to nearest dollar (current dollars)	
	December 1967	December 1972
Retired worker and wife, aged 62 and over, both receiving benefits	$144	$273
Aged widow	75	138
Retired worker	85	162
Widowed mother and 2 children	224	387

However, rising prices have stripped away a significant portion of these economic advances. For example, the four across-the-board raises have boosted average monthly benefits for retired workers from $86 to $131 in terms of *1968 constant dollars*. Taking into account the inflationary impact for aged widows, the "real" gain has also been considerably more modest: from $76 a month (*in constant 1968 dollars*) to $112.

B. Landmark Advances From 20 Percent Increase

A 20-percent across-the-board increase—enacted into law [4] in July 1972—provided landmark improvements for the Social Security program and its 28 million beneficiaries, including:

1. The largest dollar increase, by far, since the Social Security Act became law in 1935.

2. Cost-of-living adjustments to protect the elderly from the cruel effects of inflation.

3. Removal of nearly 2 million Americans from poverty, and without the necessity of resorting to welfare.

4. Abolition of poverty for approximately 1.2 million individuals aged 65 and above.

5. New and more realistic actuarial assumptions, based upon the concept of rising wages as opposed to the older and more conservative level wage assumption.

C. Public Law 92-603 (H.R. 1)

Further reforms in cash benefit provisions were enacted into law with the passage of H.R. 1, the 1972 Social Security Amendments.[5]

[3] Congress approved a 13-percent Social Security increase for 1968, 15 percent for 1970, 10 percent for 1971, and 20 percent for 1972. These four raises add up to 58 percent. However, since each increase is a percentage on top of the last one, the total compounds to 71.6 percent.

[4] Public Law 92-336, approved July 1, 1972.

[5] Public Law 92-603, approved October 30, 1972.

Particularly significant, more than 3 million widows and dependent widowers received an additional $1 billion in annual benefits (beginning in February 1973). Under this new provision, average payments for widows will be increased from $138 in 1972 to approximately $156 in 1973. Moreover this measure will enable an estimated 200,000 elderly widows to escape from the vice-like grip of poverty.

Major changes were also incorporated in the "retirement test": (1) The annual exempt earnings limitation for persons under age 72 was raised from $1,680 to $2,100; (2) For earnings in excess of this amount $1 in benefits will be withheld for each $2 of earnings (under prior law the $1-for-$2 feature applied only to earnings between $1,680 and $2,880. Thereafter, benefits were reduced for each dollar of earnings); (3) Earnings in and after the month in which a person attains age 72 will no longer be included (as under prior law) in determining his total earnings for the year; and (4) The amount of the exempt earnings limitation will be automatically adjusted in proportion to the rise in average earnings, whenever Social Security benefits are raised to reflect cost-of-living increases.

Other important changes included:

—An age-62 computation point for men (the same as now exists for women) will be phased in over a 3-year period.

—Persons who delay retirement between ages 65 and 72 will be entitled to a 1-percent increase in their Social Security benefits for each year that they continue to work.

—A special minimum benefit for the low-paid, but regular worker under Social Security will assure a payment of at least $170 a month for persons with 30 years of covered work experience.[6]

—Dependent widowers will be able to receive benefits as early as age 60 (instead of 62), on the same basis as for elderly widows.

II. HOW ADEQUATE IS RETIREMENT INCOME?

Recent Social Security increases have helped to reduce poverty very dramatically for older Americans in the past 5 years. In 1968, nearly 4.6 million persons over age 65 had incomes below the poverty index. It is projected that in 1973, this number will be reduced to 3.1 million—almost 33 percent below the 1968 figure.[7]

Aged poor (noninstitutionalized): Based on family income concept	*Millions*
1968	4.6
1969	4.8
1970	4.7
1971	4.3
1972 (estimated)	4.3
1973 (estimated)	3.1

But there is also a substantial amount of hidden poverty among the elderly. Nearly 2 million aged persons are not classified as poor, simply because they live in families with incomes above the poverty threshold. If these individuals were also counted, the number of impoverished aged would swell to more than 5 million in 1973, or almost one out of every four persons 65 or older.

[6] The special minimum monthly benefit is equal to $8.50 multiplied by the number of years of covered employment above 10 years, but not greater than 30 years. The regular minimum Social Security benefit is $84.50 a month. Consequently, the new special minimum payment ranges from $85 a month (for persons with 20 years work experience) to $170 (30 years of covered employment).

[7] The 1972 poverty index is projected by the Social Security Administration to be approximately $1,980 for a single aged person and $2,520 for an elderly couple. In 1973 it is estimated that the poverty standard will be $2,100 for individuals 65 or older and $2,640 for aged couples.

Social Security benefits for millions of older Americans—even with the 20-percent increase—still fall below the Government's own poverty benchmark.[8] Average annual payments for retired workers amounted to $1,944 in 1972, nearly $40 below the poverty threshold for single aged persons. For widows, average benefits were more than $320 under the impoverished standard.

Because Social Security benefit increases are ordinarily pegged to a low base, the elderly usually receive far less in additional money income than workers who are entitled to salary raises. For example, average benefits for retired workers have increased by more than 80 percent (from $85 a month to $162 a month) from 1967 to 1972. On an annualized basis, this percentage increase has boosted the elderly retiree's income by $924. On the other hand, hourly wages for production workers in manufacturing have increased from $2.91 in December 1967 to $3.95 in December 1972, for a 36-percent gain. Even though this percentage increase is less than one-half the percentage raise for the retiree, the wage earner's annual income (assuming he worked full time at 40 hours a week for the full year) would be boosted by $2,163 during this same period, $1,200 more than a retired worker received from Social Security increases enacted during the past 5 years.

Moreover, the Bureau of Labor Statistics Intermediate Budget (estimated at $5,200 for elderly couples and $2,860 for single persons in 1973) is beyond the means of most older Americans. Nearly 11 million aged persons are projected in 1973 to have incomes below this modest standard of living.

A. What Retirement Income Now Buys

Over the past 4 years (December 1969 to 1972), the Consumer Price Index has increased by almost 20 percent. All Americans, whether they be young or old, have felt the harsh effects of inflation in one form or another. But older Americans living on limited, fixed incomes have, perhaps, been victimized the most. To a large degree, inflationary pressures have neutralized earlier improvements in Social Security and Railroad Retirement benefits.

Moreover, the rise in prices has often been sharpest for services or products of special importance to the elderly:

—Property taxes have jumped by 39 percent, nearly twice the overall increase in the Consumer Price Index. And the impact has been especially severe for the aged because nearly 70 percent own their homes.

—Public transportation costs have risen by one-third (32.3 percent) during this same period. Here again, the elderly have been especially hard hit, since many must rely on public transportation because only about 42 percent of all older Americans are licensed to drive. In addition, transportation is the third ranking expenditure in the BLS Intermediate Budget, accounting for about 9 percent of the elderly's limited resources.

—Maintenance and repair charges for housing have also increased by nearly one-third (32.1 percent). For the aged this added burden has been onerous because housing is their number one expenditure, accounting for almost 34 percent of their budget.

[8] See footnote 7 p. 14, for the poverty index.

B. Inflationary Pressures Intensify

Inflationary pressures intensified at the end of 1972 and in early 1973, squeezing the elderly's budgets even tighter. Spearheaded by a staggering increase in food costs—the second ranking expenditure of the elderly—the Consumer Price Index soared at an annual rate of 6 percent from December 1972 to February 1973. Food prices increased by an astounding 24 percent on an annual basis during this same period.

Once more, the aged have been especially hard hit because they spend about 27 percent of their income for food, compared with 17 percent for all Americans.

III. FUTURE DIRECTIONS IN SOCIAL SECURITY

Senator Frank Church, Chairman of the Senate Special Committee on Aging, was the leader of the Senate effort for a 20-percent Social Security increase in 1972. He also supported and welcomed other major victories described in this chapter.

Nevertheless, on January 15, 1973, he opened committee hearings on "Future Directions in Social Security."

In his opening statement, he gave his reasons:

—The United States still falls short of one of his personal goals: elimination of poverty among the elderly.

—The time has come for "an updating of public understanding about Social Security."

—The hearings will pay special attention to the increased contributions rates: the boost in payroll tax from 5.2 percent to 5.85 percent for 1973 through 1977 and the increase in maximum wage base from $9,000 in 1972 to $10,800 in 1973 and up to $12,000 in 1974.

"There is no doubt," said the Senator, "that the increased contributions rate is causing some alarm among workers who this month felt the first impact of the increased payroll tax. It is essential, therefore, that this Committee hear from those who have suggestions for making this payroll tax more equitable for low-income and middle-income workers."

Senator Church added: "It is also essential, in my view, that the contribution system remain in effect. It is the basis of the almost universal confidence that Americans have in Social Security."

A. Commissioner Ball's Assessment

Commissioner Robert Ball was the lead-off witness in the committee's opening round of hearings on "Future Directions in Social Security." His assessment of the Social Security program was directed at five major areas:

1. What Social Security is;
2. Who has protection;
3. How much beneficiaries receive;
4. How much workers pay; and
5. Social Security and Public Assistance.

Commissioner Ball emphasized that Social Security offers more than protection against loss of wages because of retirement; it also provides family security. About 19 out of every 20 young children and their mothers have survivors protection under Social Security. In fact, insurance protection for a worker with a wife and two children—where the worker's average earnings are $600—is valued at $89,480 and is guaranteed inflation proof. Nearly four out of five persons aged 21 to 64 (78 million persons) are also insured for disability benefits under Social Security.

Another major point made by the Commissioner is that the contribution rate for the cash benefits program can be stabilized throughout the rest of this century and still meet anticipated increases because of cost-of-living adjustments.

He stated:

> This financing is enough, not only to meet all of the benefit costs and administrative expenses that fall due during this period, but to pay for those increases related to the cost of living.[9]

He concluded by discussing the impact of the new Supplemental Security Income program, as well as the tasks for the Social Security Administration in administering the program.

B. Importance of Health Costs

A major theme advanced by Nelson Cruikshank (President of the National Council of Senior Citizens) is that genuine retirement income security can never be achieved so long as heavy and unpredictable health costs threaten fixed incomes. In assessing the effectiveness of Medicare, he stated that the program had "succeeded brilliantly" in relieving most older Americans of the major burden of medical care expense and the dread fear of financial catastrophe resulting from acute illness. However, he noted three areas for improvement:

1. Preventing a rapid increase in the cost of health care.
2. Making fundamental changes in the health care delivery system to improve the quality and availability of care.
3. Responding to the long-term care needs of the very old and the chronically ill.

Mr. Cruikshank called for the enactment of the Health Security Act (S. 3 and H.R. 22) to meet the "health crisis our country faces," [10] for the following reasons:

—The Act provides the leverage and financial muscle for basic change.
—National Health Security guarantees good health care to every American, without regard to a means test.
—S. 3 removes barriers to timely care by eliminating deductibles and coinsurance.

[9] "Future Directions in Social Security", Special Committee on Aging, U.S. Senate. Testimony by Commissioner Robert M. Ball, January 15, 1973.
[10] Testimony by Nelson Cruikshank at hearings cited in footnote 9, January 22, 1973.

—The bill is the only practical answer to the economic delivery of health services because it provides health care directly at the lowest possible cost, with no waste of health dollars on private insurance carriers as middlemen and by using advance budgeting to assure effective controls on all health charges.

Mr. Cruikshank urged several interim reforms to improve Medicare and Medicaid. Among his major proposals:

1. Medicare and Medicaid should be merged in a federally administered program.
2. Medicare benefits should be expanded and payable without coinsurance and deductibles.
3. Inpatient hospital services should be covered up to 120 days (present law provides coverage for 90 days before the "lifetime reserve" becomes operative) and without limit if furnished in a nursing home owned by or affiliated with a hospital or comprehensive health service organization.
4. Medicare should be expanded to cover maintenance therapy or costly drug therapy.
5. To build cost controls into the system, doctors who choose to be paid on a fee-for-service basis should have their fees predetermined on a negotiated basis, and institutional providers should be paid on a prospectively approved budget basis.
6. A portion of the Medicare program should be financed out of general revenues.

C. Criticisms of the Payroll Tax

John Brittain, Senior Fellow at the Brookings Institution, directed his testimony at "inequities in the Social Security payroll tax and proposals for reform." His chief criticism of the payroll tax is that "it places this burden on the working poor despite the ability-to-pay criterion that exempts them from the income tax." [11] Brittain asked, "If the ability-to-pay guideline is valid for our largest and fairest tax [the Federal income tax], why should it not also be applied to the Social Security tax?" [12] He also criticized the "regressivity" of the payroll tax, in that it applies a uniform rate for covered wages up to $10,800.

To reform the payroll tax, Brittain offered a number of alternatives. First, he suggested that the payroll tax should be restructured by incorporating exemptions and deductions similar to those under the income tax. This would help to eliminate the tax on families in poverty, which he called "the least defensible feature of the payroll tax." [13] Brittain also suggested that this reform could be supplemented by increasing or removing the ceiling on the taxable wage base (now $10,800).

His second proposal provided for more substantive reforms, including full replacement of the payroll tax by the income tax. He quickly pointed out, however, that this approach may not be legislatively feasible, since it would require an increase in the income tax yield approaching 50 percent. As a more modest alternative, he suggested that the income tax could absorb the employee's share of the

[11] Testimony by Dr. John Brittain at hearings cited in footnote 9, January 23, 1973.
[12] Ibid.
[13] Ibid.

payroll tax directly, or the employee's payments could be credited against his individual income tax. Another alternative offered by Brittain would be to provide for general revenue financing of Social Security.

D. Concepts Behind Social Security

Fundamental concepts underlying the Social Security program were discussed in detail by J. Douglas Brown (Provost and Dean of the Faculty, Emeritus, Princeton University) and William L. Mitchell (former Social Security Commissioner).

Dean Brown said that contributions and benefits under Social Security are not separate entities, but must be examined together in their totality. "Without this interlock," he says, "you end up with a program of doles financed by general taxation." [14]

He also opposed proposals to remove or substantially reduce the contribution rate for low-income participants, giving this rationale:

> This close integration of contributions and benefits in the concept of contributory social insurance, paying benefits as a matter of right, is the reason why those of us who have worked longest in the development of the OASDI program oppose altering the rate of *contribution* for lower-income participants according to some ancillary test of need. . . . Helping to pay for a benefit to be received as a matter of right is an integral part of the concept. It differentiates social insurance from charity. It sustains self-respect.[15]

But Dean Brown noted that this does not mean that the financing should be borne entirely by contributions from workers and their employers. He advocated Government participation in the financing of a contributory social insurance system, pointing out that the founding fathers of Social Security and earlier advisory councils fully supported this concept.

Additionally, Dean Brown recommended that the "bend point" [16] (set at $110 in 1954) for the wage replacement formula for Social Security be raised. He stated:

> There is good reason to believe that a higher bend point is now justified, even if the slope above that point might need

[14] Testimony by J. Douglas Brown at hearings cited in footnote 9, January 23, 1973.
[15] Ibid.
[16] Social security benefits in 1973 as a percentage of average monthly earnings as defined by the Social Security Administration are as follows for men retiring effective January 1, 1973 at ages 65 and 62 (20 percent reduction), assuming a full-year of earnings in 1972:

AMW	Age 65	Percent	Age 62	Percent
100	$108.80	108.80	$87.10	87.10
200	154.40	77.20	123.60	61.80
300	193.10	64.37	154.50	51.50
400	233.30	58.33	186.70	46.68
(500)	(269.70)	(53.93)	(215.80)	(43.15)
(600)	(309.80)	(51.62)	(247.90)	(41.30)
(700)	(342.50)	(48.93)	(274.00)	(39.14)
(800)	(364.50)	(45.55)	(291.60)	(36.45)
(900)	(384.50)	(42.72)	(307.60)	(34.18)

Note.—The higher average monthly earnings shown in parentheses are not possible now for workers retiring at ages 62–65 because earnings in some of the earlier years, when the maximum amount creditable was lower, must be included in the average. The highest average monthly earnings possible for a man retiring at age 65 in 1972 is $471, in 1973, $488, based on work throughout 1972.

The larger amounts and correspondingly larger benefits shown in parentheses may be payable to workers who become entitled to disability benefits or die at a relatively young age, and in later years for age retirements.

to be slightly less steep. This would give beneficiaries in the lower part of the scale a better adjustment to their normal needs, still graduated according to their past earnings.[17]

Social Security, in the judgment of William Mitchell, was "designed to establish only a floor of protection, with the anticipation that the floor will be maintained so as to reflect social and economic changes—such as improvement in quality of livelihood and changes in wages and prices." [18]

Mr. Mitchell said that the Congress should give priority attention to ameliorating some of the regressive features of the payroll tax. But he opposed removal of the ceiling on the taxable wage base or general revenue financing as a means to implement this goal.

He also emphasized that the new automatic cost-of-living mechanism should not preclude periodic review by the Congress to insure the continued dynamism of the system. Mr. Mitchell concluded by urging that a bipartisan Social Security Board be established to help guide the future destiny of the cash benefits program, Medicare, and the Supplemental Security Income program.

IV. THE PROPERTY TAX DRAIN

Property taxes continued ominously upward in 1972, increasing by more than 9 percent. And the indications are that a disproportionate share of this burden is now shouldered by low- and moderate-income elderly homeowners.

A typical urban family of four turns over about 3.4 percent of its family income to the property tax assessor. But, aged homeowners pay, on the average, about 8.1 percent of their incomes for real estate taxes.

A recent study by the Advisory Commission on Intergovernmental Relations (based upon 1970 Census data) reveals that aged homeowners living on less than $2,000 a year pay almost 16 percent of their meager incomes for this regressive tax. Moreover, an estimated 1.5 million elderly households with incomes below $7,000 a year are saddled with property taxes amounting to more than 10 percent of their household income.

Renters also feel the squeeze from high property taxes, since landlords oftentimes shift a major share of this burden to them. Assuming that 25 percent of gross rent constitutes property tax, nearly 70 percent of all aged renters living on less than $5,000—or more than 1.9 million households headed by a person 65 or older—pay the equivalent of 8.75 percent or more of their incomes for property tax.

A. Administration Position

At the White House Conference on Aging, President Nixon listed property tax relief as one of his highest priorities for older Americans. He said, "I am therefore preparing specific proposals to ease the crushing burden of property taxes for older Americans, and for all Americans." [19]

[17] Testimony by J. Douglas Brown at hearings cited in footnote 9, January 23, 1973.
[18] Testimony by William Mitchell at hearings cited in footnote 9, January 23, 1973.
[19] Text of an address by President Richard Nixon to the Delegates to the White House Conference on Aging, Washington, D.C., December 2, 1971, "1971 White House Conference on Aging: A Report to the Delegates From the Conference Sections and Special Concerns Sessions", S. Doc. 92-53, December 1971, p. 129.

No Administration recommendations though were introduced during 1972. However, in an interview with the Star-News, John Erlichman, Presidential Assistant for Domestic Affairs, indicated that specific measures would be outlined in detail "in relatively short order." [20] He also stated that the Administration's goal was to cut property taxes in half for everyone.

The 1973 Message on Human Resources reiterated the pledge to provide property tax relief for the elderly.

B. Report by the Advisory Commission on Intergovernmental Relations

Another major development was the Advisory Commission on Intergovernmental Relations Report,[21] which was issued in January 1973. In a close vote the Commission rejected a proposal for the national government to assist States in establishing programs to provide limited property tax relief to low-income homeowners and renters.[22]

The Commission gave this rationale for its decision:

> . . . Admittedly, there is considerable evidence to support the contention that this particular Federal aid proposal could pass the first test because to date most States have not shielded low-income homeowners and renters from property tax overload situations. This State failure, in turn, clearly undercuts a major national program objective of income support especially through the Social Security system. In the view of the majority of the Commission, however, the proposal failed to meet the second national interest test—that only Federal action could resolve this intergovernmental conflict.[23]

Instead, the Commission reaffirmed its earlier recommendation that the States should take action to shield basic family income from burdensome property taxes.

FINDINGS AND RECOMMENDATIONS

Social Security provides protection against loss of earnings because of retirement, death, and disability for workers and their families. It also keeps more than 12 million persons out of poverty. Without these benefits, millions of individuals would be forced onto the the welfare rolls.

Social Security also constitutes the economic mainstay for the vast majority of older Americans. Nearly two-thirds of retired single workers and half of aged couples depend upon Social Security for more than 50 percent of their income. These benefits are almost the

[20] The Evening Star and Daily News, "Nixon Target: Property Taxes" by Garnett D. Horner, November 10, 1972, p. A-1.

[21] "Financing Schools and Property Tax Relief—A State Responsibility", The Report in Brief A-40 Advisory Commission on Intergovernmental Relations, January 1973.

[22] Senator Edmund Muskie and Senator Charles Percy dissented from this decision. In separate statements, both Senators expressed the opinion that a limited Federal program to encourage the States to undertake property tax relief and reform was both justifiable and necessary. (For text of dissenting statements see footnote 21, page 4 of ACIR Report cited previously.) On March 15, 1973, Senators Muskie and Percy joined in cosponsoring legislation—S. 1255, The Property Tax Relief and Reform Act of 1973—to provide such a program of Federal assistance.

[23] Page 4 of report cited in footnote 21.

sole means of support (over 90 percent of total income) for 32 percent of retired workers and 14 percent of elderly couples.

For these reasons it is crucial that (1) the Social Security system continue to be built upon the soundest possible foundation in a dynamic economy, and (2) the financing of this essential system be equitable for all concerned. As a means to insure the further implementation of these two guiding principles, the Committee on Aging has initiated a comprehensive inquiry into "Future Directions in Social Security." Virtually all major aspects of the Social Security program will be examined in depth by the committee, including:

—What can be done to improve the payroll tax;
—The treatment of working wives under Social Security;
—How can retirement be made more secure for elderly women;
—The special problems of elderly members of minority groups, so many of whom never live to age 65;
—The retirement test; and
—Other crucial issues.

The committee recommends that the income standards under the new Supplemental Security Income program be raised in the near future to a level which can, at long last, abolish poverty for the elderly. Additionally, the committee calls for the adoption of cost-of-living adjustments for the SSI program to protect low-income older Americans from the harmful effects of inflation.

The committee further finds that the property tax burden has now reached crisis proportions in many communities throughout the Nation for millions of elderly homeowners and renters. For this reason the committee urges that a property tax relief program—financed in part by Federal resources—be enacted promptly to shield aged homeowners and tenants from the effects of confiscatory property taxes. This form of assistance should be targeted to States which establish "circuit-breaker" tax relief mechanisms with a "tier" system to direct relief to property owners and tenants most in need. It is also recommended that such a program of Federal assistance be tied, where appropriate, to adoption by the States of certain long-overdue reforms in property tax administration.

CHAPTER III

BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

To those who took an optimistic view, early 1972 was a time of high hopes for improved health care for the elderly. Today it is clear that such optimism was not justified. Many barriers continue to stand in the way of older Americans seeking better health care.

But what were the reasons for hope in the beginning months of 1972? Several can be cited.

First, the 1971 White House Conference on Aging had set forth solid recommendations in the health field.[1]

Second, President Nixon, in his 1972 message on aging, cited the high costs of medical care for the elderly and stated that "Older Americans often find that they must pay their *highest* medical bills at the very time in their lives when they are *least* able to afford them." [2] The President seemed aware of the problems and committed to solutions.

Third, President Nixon, in his 1972 health message, stated that:

> An all-directions reform of our health care system—so that every citizen will be able to get quality health care at reasonable cost regardless of income and regardless of area of residence—remains an item of highest priority on my unfinished agenda for America in the 1970's.[3]

Again, the President was indicating special attention to health care problems.

Fourth, Phase II of the Administration's "New Economic Plan" was in high gear.[4] All Americans—and especially the hard-hit elderly—wanted this approach to succeed in putting the lid on soaring health care costs.

Fifth, H.R. 1, the omnibus welfare reform-Social Security bill, was under consideration in the Congress. Its potential was great for effecting needed improvements in Medicare and Medicaid.

What happened to the promise that some saw in early 1972 for more and better health care for the elderly? Answers to this question will be offered in the following analysis.

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[1] "1971 White House Conference on Aging: A Report to the Delegates from the Conference Sections and Special Concerns Sessions," reprinted by the U.S. Senate Special Committee on Aging, December 1971, pp. 8–11. (All references to White House Conference on Aging recommendations are taken from this publication.)

[2] Message from the President of the United States Transmitting Recommendations for Action on Behalf of Older Americans, Mar. 23, 1972, p. 10. (H. Doc. 92-268, 92d Cong., 2d Sess.). (All references to the President's message on aging are taken from this document.)

[3] U.S. President. Weekly Compilation of Presidential Documents. Vol. 8, No. 10, p. 504. (All references to the President's message on health are taken from this document.)

[4] Under Phase II, a 2.5 percent limit was imposed on rises in doctors' fees and a 6-percent ceiling was clamped on rises in hospital charges. Practitioners, hospitals, and other components of the health field were required to maintain price lists disclosing any changes and to make such lists available to patients. Exceptions to the 2.5 percent and 6 percent standards could be granted in special circumstances.

I. HEALTH CARE COSTS: STILL A MAJOR DRAIN

Health care costs for the elderly are still a major drain, despite Medicare and Medicaid.[5] Hard facts, outlined below, support this conclusion.[6]

—***Out-of-pocket, per capita direct payments for medical treatment of the aged are now actually higher than they were before Medicare began. In fiscal year 1966, they were $234. In fiscal year 1972, they had climbed all the way to $276, or $42 more than the year before Medicare became law. These out-of-pocket payments do not, however, include the Part B premium charge, which, during fiscal year 1973, will amount to $69.60.***

—Average expenditures for those 65 and over in fiscal year 1972 were $981, about six and two-thirds times that for the under-19 age group ($147) and about two and two-thirds times that for persons aged 19–64 ($358).

—The aged, who constitute only 10 percent of the population, accounted for 27 percent of health expenditures of the national total of $71.9 billion spent for personal health care in fiscal year 1972, because of their greater use of medical care services and their costlier illnesses.

—The average annual increase in the Consumer Price Index from 1971 to 1972 for the medical care component was 3.2 percent. Available figures for 1973 show continuing increases: 0.4 percent from December 1972 to January 1973 and 0.3 percent from January 1973 to February 1973.

II. LIMITED HELP FROM MEDICARE AND MEDICAID

Despite the valuable protection afforded by Medicare, in fiscal year 1972 it covered only 42.3 percent of the total health payments of the elderly. (This percentage would be even lower if the Part B premium charge were considered an out-of-pocket payment.) This was the same percentage as that for fiscal year 1971 and represented a drop from 45.5 percent in fiscal year 1969.[7] Gaps in coverage include such major items as essential out-of-hospital prescription drugs and adequate provision for long-term care.

Costs to participants in the Medicare program have been rising steadily since its inception.

The Part B premium, for example, was $3 a month in July 1966. It has been increased several times since then and now stands at $5.80 monthly. In July 1973, this monthly charge will be hiked to $6.30.

The deductible for Part A hospital insurance was $40 when Medicare went into effect in July 1966. This deductible has also been subject to increases since then and reached $72 on January 1, 1973.

Still further increases became effective January 1, 1973. When a Medicare beneficiary has a hospital stay of more than 60 days, he

[5] The limited help from Medicare and Medicaid is discussed in section II of this chapter, which includes a review of recent increased costs to participants in these programs.

[6] The Consumer Price Index figures cited in this section are from *Consumer Price Index*, Bureau of Labor Statistics, U.S. Department of Labor. All other figures in this section are taken from Barbara S. Cooper and Nancy L. Worthington, "Age Differences in Medical Care Spending, Fiscal Year 1972," *Social Security Bulletin*, May, 1973.

[7] These figures are from the *Social Security Bulletin* article cited in footnote 6.

started paying, as of January 1, 1973, $18 a day for the 61st through the 90th day, up from $10 when Medicare was enacted. If he has a posthospital stay of over 20 days in an extended care facility, he began paying, as of January 1, 1973, $9 per day toward the cost of the 21st day through the 100th day, up from $5 when Medicare began.

If a Medicare beneficiary needed to draw on his "lifetime reserve"—the reserve of hospital days a beneficiary can utilize if he ever needs more than 90 days of hospital care in the same benefit period—he started paying, as of January 1, 1973, $36 for each day used, instead of the $20 charge under the original Medicare law.

Significance of H.R. 1

H.R. 1, enacted as Public Law 92–603 in the closing days of the 92d Congress, imposed new cost-sharing requirements under Medicare and Medicaid. The practical effect of these provisions is more financial burdens for the elderly in need of health care. For example, as a result of Public Law 92–603, effective January 1, 1973:

—The annual part B deductible under Medicare was increased from $50 to $60;
—States which cover the medically indigent under Medicaid were required to impose monthly premium charges;
—States could impose copayment and deductible charges on the medically indigent in Medicaid programs; and
—States were permitted to subject cash assistance recipients to deductibles and copayments for optional Medicaid services.

No discussion of Public Law 92–603 would be complete without reference to at least some of the gains to Medicare beneficiaries as a result of its enactment. These include the following:

—*Medicare coverage for the disabled.* Nearly 1.7 million disabled Social Security beneficiaries under age 65 are entitled to Medicare coverage, provided they have been entitled to benefits for at least 24 months.
—*Protection against retroactive denial of payments under Medicare.* The Secretary of Health, Education, and Welfare is authorized to establish, by diagnosis, minimum periods after hospitalization during which a patient is presumed to be eligible for extended care or home health coverage.
—*Payments to Health Maintenance Organizations (HMO's).* Medicare beneficiaries are authorized to enroll in prepaid group health plans, with the Government paying the HMO on a capitation basis.
—*Home Health Insurance.* The coinsurance requirement of 20 percent of the reasonable charges—after the $60 deductible under part B is met—is eliminated for home health services under part B.
—*Coverage of Persons Needing Kidney Transplantation or Dialysis.* Medicare protection is provided against the costs of hemodialysis and kidney transplantation for almost all Americans afflicted with that disease, beginning after the third month of treatment.

These and other positive provisions contained in Public Law 92–603 should not be minimized. They strengthen the Medicare program, and they are important steps forward.

But these harsh realities remain:

1. Since the inception of Medicare, the elderly health consumer has faced steadily mounting costs as a condition of participation; and

2. Public Law 92–603 includes regressive provisions which add to these costs under Medicare and also Medicaid as well.

III. THE ADMINISTRATION PROPOSALS: 1973

How has the Administration reacted to the escalating costs of health care to the Nation's elderly? Two developments are especially noteworthy.

First, in January 1973, the Administration abolished almost entirely its "Phase II" economic controls. It is now relying mainly on voluntary guidelines. But during "Phase III" the health care industry remains under mandatory controls. This is a clear indication that health care costs continue as a major problem.

Second, President Nixon's budget proposals for fiscal 1974 contain recommendations for increased "cost-sharing" by Medicare beneficiaries. Under the Administration's proposals, those on Medicare would be required to pay for:

1. Actual hospital room and board charges for the first full day plus 10 percent of all subsequent charges, instead of—as at present—the $72 deductible and nothing else until the 61st day;

2. The first $85 of doctor bills, instead of the current $60; and

3. Twenty-five percent, as opposed to the existing 20 percent, for physician services after the part B deductible is met.

These recommendations to increase patient "cost-sharing" under Medicare, taken together with a number of related administrative actions, would, according to the Administration's own estimate, reduce the fiscal year 1974 Medicare budget by $893 million.[8] Since this estimate applies to only 6 months of calendar year 1974, it seems reasonable to assume that the total budgetary savings for calendar year 1974 would amount to over $1.7 billion.[9] The elderly would be paying a large portion of this sum out of their own pockets.

The Administration proposals were advanced in the face of:

1. The 1971 White House Conference on Aging health recommendations, which specifically called for "elimination of deductibles, coinsurance, and copayment" under Medicare;[10]

2. References in President Nixon's 1972 messages on health and on aging which cited the need to curb medical costs and recognized the special problems of the elderly in trying to pay for quality health care; and

3. Steadily-rising medical costs confronting the elderly.

The Administration proposals were a major focus of March hearings conducted by a unit of the Senate Special Committee on Aging.

[8] U.S. Department of Health, Education, and Welfare press release accompanying the President's fiscal year 1974 budget, Jan. 1973, p. 91.

[9] For additional documentation on this point, see "The Budget of the United States Government, Fiscal Year 1974," H. Doc. 93–15, 93d Cong., 1st Sess., at p. 50 ("Reform Medicare cost-sharing and implement effective utilization review" entry) and p. 52 ("Strengthen Medicare cost controls and eliminate unnecessary advance payments for hospitals" entry).

[10] At p. 9 of the source cited in footnote 1.

IV. HEARINGS TO EXPLORE "BARRIERS"

On March 5 and 6, 1973, the Subcommittee on Health of the Elderly, chaired by Senator Edmund S. Muskie, opened hearings in Washington on "Barriers to Health Care for Older Americans."

These hearings, which will be continued in Washington and elsewhere in the Nation, are meant to serve two purposes.

A. Medicare Cutbacks

The first purpose of the hearings is to take an intensive look at the Administration's proposals for Medicare cutbacks. In his opening statement on March 5, Senator Muskie asked this question:

> How can many of our elderly realistically expect to receive adequate medical care, in the face of these proposed Medicare cutbacks?

Secretary Weinberger, testifying before the subcommittee, said that cutbacks would encourage more cost awareness by health consumers and thereby minimize overutilization of medical services. But most Social Security recipients are already painfully aware of the high costs of medical care as they struggle on low budgets. In addition, doctors, not patients, determine utilization.

The Secretary also said that the Administration's proposal would aid long-term hospital patients because they are usually less able to meet costs of care as their stays increase. But, under the Administration plan, only after 92 days in the hospital would Medicare beneficiaries pay less than they do now. And only about 1 percent of the Medicare population is likely to be hospitalized for 92 days or more.[11] *So the Administration would increase "cost-sharing" for about 99 percent of Medicare hospital patients in order to lower costs for about 1 percent.*

Mr. Weinberger further maintained that the Administration proposals would encourage consumers to seek lower-cost alternative health services or facilities. But in many cases such alternatives do not exist.

Points made during the Secretary's two and one-half hours of testimony were challenged by other witnesses. Mrs. Marjorie Cantor, Research Director, New York City Office for the Aging, told the human story of what the cutbacks would mean in two typical examples.

Mrs. Cantor's first example concerned the costs to an elderly person for 21 days in a New York City hospital. That is about the average stay for an older person in that city's hospitals. The average daily cost of $110 for semiprivate room and board charges was used. Excluded were laboratory fees, drugs, nursing care, and other items generally completely covered by Medicare after the initial deductible is paid by the elderly patient. Currently, this patient would pay $72 out of his own pocket.

Under the Administration's Medicare changes, the same patient would pay $330, a 358 percent increase in out-of-pocket costs.

In the first example cited by Mrs. Cantor, it was assumed that the Administration proposal would make Medicare patients pay for the

[11] These figures, based on conservative assumptions, have been provided by the Congressional Research Service of the Library of Congress (in response to a request from the committee).

actual hospital room and board charges for the first day plus 10 percent of all subsequent hospital room and board charges. Testimony by Secretary Weinberger, however, made it clear that the Administration would require such patients to pay for actual hospital room and board charges for the first day plus 10 percent of *all subsequent charges*. The administration proposal would, therefore, mean even greater out-of-pocket costs to the patient in Mrs. Cantor's first example.

The second example Mrs. Cantor cited involved a chronically ill, elderly woman with a common ailment of old age, congestive heart failure. In calculating this patient's doctor's bills, the standard fees in New York City were used. It was also assumed that the fees were within Medicare reimbursement schedules and that the patient would not have to pay any additional costs beyond the 20 percent coinsurance. Medicare charges for this patient, under existing law, would amount to $225 in doctor's fees for the year. If the Administration's Medicare cutbacks became law, her out-of-pocket payments for doctor's bills would increase to $285, or almost a one-third jump.

Melvin A. Glasser, Director, Social Security Department, United Automobile Workers, disagreed with the argument that increasing deductibles and copayments has a positive effect in moderating utilization. Glasser said existing studies are equivocal on this point. In addition, he pointed to the lack of evidence that the elderly "overutilize" the health care system relative to other groups.

Professor Charlotte Muller, Center for Social Research, City University of New York, indicated that the changes in Medicare proposed by the Administration would result in standards below those announced for marketable insurance by the Superintendent of Insurance for New York State.

Congressional opposition to the Medicare cutback proposals is running high. Senator Walter F. Mondale, a member of the Special Committee on Aging, introduced on March 26, 1973, a concurrent resolution rejecting the Medicare cutbacks proposed by the President.[12] This resolution has the support of a bipartisan majority of the Senate.

Senator Frank Church, chairman of the Special Committee on Aging, in adding his name as a cosponsor of the Mondale resolution, stated:[13]

> Although most of the proposed changes cannot be implemented without Congressional action, confusion and fear already exist among countless senior citizens that the action will be taken. The resolution is designed to express the intent of Congress that the changes not take place.

B. Identifying Other Barriers

The hearings are also designed to serve a second purpose: the subcommittee will be working toward a fuller understanding of the barriers to health care for the elderly and what can be done to remove them or reduce their bad effects. Senator Muskie, in his opening statement on March 5, identified the issues of particular interest to the subcommittee:

[12] S. Con. Res. 18. Congressional Record, Mar. 26, 1973, p. S5637.
[13] News release from Senator Frank Church, Mar. 23, 1973.

—How spiraling health care costs are crippling Medicare and Medicaid.
—Why adequate alternatives to needless institutionalization are not being developed and why home health care resources are dwindling.
—How fragmentation of medical services is intensifying the health care dilemma, especially in inner cities and rural areas.
—Whether coinsurance and deductibles, in fact, serve a socially desirable purpose.
—How can Medicare and Medicaid costs be controlled, while assuring equitable treatment for those served by these programs.
—How the elderly should be served in whatever national health security program finally comes into being.

V. HOME HEALTH CARE

The lack of adequate home health services is one of the major barriers to better health care for older Americans. As a report to the committee points out: [14]

—Medicare and Medicaid erect barriers to the development of home health services;
—Home health agencies are declining in number and many others face serious financial problems; and
—Not even 1 percent of Medicare expenditures goes to home health care and that figure seems to be getting smaller.

These and other findings are supported in a later GAO study, which also makes these points: [15]

—Health care authorities agree "that about 25 percent of the patient population are treated in facilities which are excessive to their needs."
—A better matching of hospital patient needs with facilities' services "could result in 81.7 million short-term general hospital days' being transferred to alternative health facilities," at a savings of about $3 billion (citing a 1968 PHS cost-effectiveness analysis).

The GAO report concludes that "efforts should be made to exploit all alternatives to acute inpatient care," with special attention to (among others):

—Increasing ambulatory outpatient facilities;
—Establishing effective preadmission testing;
—Converting underused beds to general medical-surgical uses; and
—Third-party financing of needed health care regardless of where it is provided.

New information which has reached the committee indicates that the situation is continuing to decline as far as home health services are concerned. For example, the number of certified home health

[14] "Home Health Services in the United States," U.S. Senate Special Committee on Aging, April, 1972. This report is also discussed in "Developments in Aging: 1971 and January–March 1972," U.S. Senate Special Committee on Aging, May 5, 1972, pp. 27–28.
[15] "Study of Health Facilities Construction Costs," Report to the Congress by the Comptroller General of the United States, November 20, 1972. All references to and quotations from this study are taken from the official report, No. B–164031(3).

agencies at the end of 1972 is reported to have been 2,221. The figure given as of 1970 was 2,350 and as of December 1971, 2,256.[16]

FINDINGS AND RECOMMENDATIONS

The promise that some saw in the early months of 1972 for improved health care for the elderly has not been fulfilled. Instead, there have been setbacks which must be reversed if the elderly are to get the better health care they need and deserve.

Health care costs are still a major drain on the limited incomes of the elderly, and this drain is getting worse, not better.

Medicare and Medicaid are limited programs in which costs to participants continue to rise. Public Law 92–603, while making several historic improvements, has negative provisions which further curtail their effectiveness and serve to increase the difficulties faced by the elderly in trying to get decent health care at a cost within their reach.

The committee strongly opposes the Administration proposals for Medicare cutbacks and urges Congress to reject them.

The Subcommittee on Health of the Elderly has initiated hearings on "Barriers to Health Care for Older Americans." Through these hearings—and related reports—the subcommittee plans to identify key barriers to better health care for the elderly and to recommend ways to remove them.[17] One important focus of this effort will be the vital area of home health care.

[16] The figures in this paragraph are taken from information supplied to the committee by its home health consultant, Brahna Trager, on Mar. 2, 1973.

[17] One major barrier is the lack of Medicare coverage for essential out-of-hospital prescription drugs. On Jan. 31, 1973, Senator Frank Church, Chairman of the Special Committee on Aging, introduced S. 631. This bill would amend the Social Security Act to provide for the coverage of certain drugs under Part A of Medicare.

CHAPTER IV

THE NURSING HOME SCENE TODAY

In 1972 and early in 1973, nursing homes continued to claim a major share of public attention. The President's proposed budget for fiscal 1974 would allocate $2 billion to long-term care. Some long-waited Medicare-Medicaid reforms were finally enacted when H.R. 1 became Public Law 92-603. Other H.R. 1 provisions, however, have already come under attack. One major fear was that new intermediate care facility regulations—if adopted—could intensify the "dumping" problem which occurs when financially hard pressed units of government attempt to reduce overall budgetary costs by taking patients from higher-cost facilities and placing them in other, less costly—and often inappropriate—units.

I. WHAT IS IN H.R. 1

Many of the provisions in H.R. 1 of 1973 spring from the determination of the Senate Finance Committee and the House Ways and Means Committee to reduce waste, mismanagement, outright fraud in the costly Medicare and Medicaid programs.

As Finance Chairman Russell Long expressed it when he opened investigative hearings back in July 1969:

> Today we are quite capable of identifying and pinpointing major areas of concern—including widespread abuse and fraud as well as lax administration. It appears as if almost everyone in Medicare wants to make an extra buck at the expense of the taxpayer and the millions of older people in Medicare.[1]

One reason for such concern was the rapidly rising cost estimates of both programs.

H.R. 1 responded to the need for cost controls, and it also added new provisions intended to make Medicare and Medicaid more effective and efficient for patient and providers of services.

Among the major reforms were:

A. Changes in Medicare

Perhaps the most important provision to providers (also the subject of a bill, S. 1827) was section 228, which authorized the Secretary of HEW to establish minimum periods during which the posthospital patient would be presumed to be eligible for benefits. This was an attempt to deal with the "retroactive denial" problem, or refusal to pay for care after it had been given.

[1] Hearings by the Senate Committee on Finance, "Medicare and Medicaid," July 1 and 2, 1969, p. 1.

Section 243 authorizes Provider Reimbursement Review Boards to hear cases involving $10,000 or more. Prior to this provision an administrator had no recourse to appeal procedures.

Section 201 authorizes Medicare coverage for the disabled, meaning those meeting the Social Security Administration's definition of disability for 24 prior and consecutive months.

Section 229 authorizes the Secretary to terminate payments to providers who are found to abuse the system.

Section 242 provides penalties for offering, soliciting, or accepting bribes, kickbacks, or for concealing events affecting a person's rights to benefit with intent to defraud and for converting benefit payments to improper use of up to 1 year's imprisonment and a $10,000 fine.

Section 246 and 247 are most significant in that they bring about the unification of the title 18 (Medicare) and title 19 (Medicaid) nursing home programs. Both of these programs provided "skilled nursing" but under separate standards. These standards are now to be unified. (Detailed comments on these provisions follow.) The term "extended care facility" will fade into the past, replaced by the new term "skilled nursing facility," which is defined as "an institution meeting the present definition of an extended care facility and which also satisfies certain other Medicaid requirements as set forth in the Social Security Act." Further, section 249 mandates that these facilities be reimbursed on a reasonable cost-related basis.

Section 249(F) establishes Professional Standards Review Organizations (PSRO's) to consist of substantial numbers of practicing physicians in local areas to assume responsibility for comprehensive and on-going review of services covered under the Medicare and Medicaid programs. These organizations will be responsible for assuring that the services are medically necessary and provided in accordance with professional standards.

Section 249(C) allows the Secretary to make public program validation reviews and individual contractor performance reviews.

Section 265 eliminated the previous Medicare requirement that nursing homes have a social worker under contract to see to the needs of patients.

Section 267 allows a waiver of the existing staffing requirement under Medicare. Previously, one registered nurse was required 7 days a week, 8 hours a day. The amendment allows facilities in rural areas to have RN coverage only 5 days a week.

Section 269 codifies a waiver exempting nursing home administrators who had served in such capacity for 3 years previously from the State's licensure requirements.

Criticism of the Medicare Provisions: Concern about some aspects of H.R. 1 have been expressed by Senator Frank E. Moss, chairman of the Subcommittee on Long-Term Care of the Senate Committee on Aging, and other congressional authorities on nursing homes.

For example, an already inadequate standard has been weakened further. One registered nurse (RN) 8 hours a day, 7 days a week and a minimum of a licensed practical nurse (LPN) in charge of the other shifts was the existing standard under Medicare. Some States like Connecticut, however, require RN coverage around the clock with a ratio of one RN for every 30 patients on the day shift and one RN for every 45 at night. Lowering the existing Medicare standard

to one RN 5 days a week in the name of shortages in rural areas is regrettable, particularly in view of the testimony received by the Subcommittee on Long-Term Care. For example, Rev. John Mason, representing nonprofit Lutheran Homes of America, and William D. Eggers, president of the American Association of Homes for the Aging, testified: (1) there is a tremendous pool of retired registered nurses who could be brought into service if conditions in homes and pay were adequate, and (2) that good nursing homes have no difficulty getting nurses even in rural areas.[2]

The watering down of the 1967 amendment requiring the licensure of nursing home administrators takes much of the force away from the existing law and could throw State laws into confusion. It is significant that this action was taken against the wishes of the American College of Nursing Home Administrators, which stated:

> It must be realized that an individual's exposure to an administrative position alone is an insufficient measure of his ability to provide proper patient care. Education and demonstrated ability in addition to the successful passing of a specifically designed process must also be required.

Senator Abraham Ribicoff, who opposed the two above amendments, also tried, unsuccessfully, to delete section 265, which removes the Medicare social workers requirement. His comments are included in the February 29, 1972, Congressional Record:[3]

> The aging patient entering a nursing home has left his home, his friends, and his family behind. He is likely to be confused, frightened, and alone and needs personal attention which doctors cannot provide. The social workers can alleviate this suffering and fright by providing counseling, letterwriting assistance, consultation with the family, and companionship. The social worker in the nursing home assures the patient that there is someone to care for his personal and emotional needs.
>
> Present regulations specify that an extended care facility must have effective arrangements with a public or private agency to provide social service consultation. The nursing home industry claims that many facilities have had difficulty in obtaining such services and that they are often expensive.
>
> Section 265 of H.R. 1 deletes the provision of medical social services as a condition of participation for a nursing home.
>
> Most extended care facilities currently licensed by medicare are privately owned and operated for profit. They tend to meet only the minimum requirements set by medicare and do not, as a rule, provide optional, extra services for their patients. If section 265 were enacted, many facilities would therefore eliminate social services. Figures in December 1969 showed that the highest number of nursing home deficiencies, 37 percent, occurred under the social services requirement for extended care facilities.
>
> My amendment, therefore, continues the requirement that social services be provided.

[2] Hearings by the Subcommittee on Long-Term Care, "Trends in Long-Term Care," July 30, 1969, pt. 1, p. 77.
[3] Congressional Record, Feb. 29, 1972, Vol. 118, No. 29, p. 2792.

Another provision in H.R. 1 makes public certain Medicare reports, but it is far from the original intent of its sponsor, Senator Ribicoff. The Senator intended that inspection files and records on nursing homes participating in Federal programs be made available so that the public and press might have some basis for judging the compliance with standards and the quality of care provided in such facilities.

It is hoped that the provision for PSRO's will be effective although there may be inherent limitations in any such evaluative procedures. Moreover there are similarities between PSRO's and the existing provisions for medical review. Medical review is claimed to be superior to professional review by some advocates. Medical review is conducted by a team of health professionals including nurses, therapists, and social workers who evaluate the quality of the care provided and the appropriateness of the existing facility to meet patient's needs, along with an assessment of whether an alternative facility might better meet those needs. The PSRO concept is physician-dominated, causing some advocates to suggest that amendments are necessary to insure consumer representation on such organizations.

Even in the best of circumstances such "peer review" procedures are no panacea, according to Arthur Jarvis, deputy director of the Connecticut Department of Health. In testimony before the Subcommittee on Long-Term Care,[4] he said:

> . . . These self-audit committees take several forms but operate in much the same manner; namely, the medical record of a discharged patient is reviewed by a peer group of physicians appointed to that committee by the chairman of the medical staff.
>
> The scope of the review is essentially to match up the diagnosis made by the attending physician with what prediagnostic examinations he ordered and, following confirmation of diagnosis, what drugs and treatment he ordered. Included in this of course, the committee evaluates the effectiveness of the treatment ordered and the attempt here is to adjudge that this particular patient received the proper care and achieved the amount of "cure" possible in relationship to the patient's diagnosis and prognosis.
>
> . . . medical peer group, self-audit committees go back to the teens and the twenties of this century.
>
> * * * * * * *
>
> However, these committees did, and still have, the built-in weakness of a subjective, if not honest, difference of opinion between a physician on an audit committee reviewing the medical record of another physician. In other words, physician A who is reviewing the chart may make the decision that such and such a decision, or procedure, was not the appropriate treatment or service that should have been ordered in view of the diagnosis.
>
> On the other hand, physician B, the attending physician responsible for the medical record and his patient, may disagree and say, "I am sorry, but in my judgment this was the best way to handle the case." Thus it is that while we in

[4] "Trends in Long-Term Care," Hearings by the Subcommittee on Long-Term Care, Part 3, Hartford, Conn., Jan. 15, 1970, p. 289.

the hospital field and our colleagues in the physician community have been able to take pride that such peer group self-evaluation is going on, and has been for some years, the problem of medically subjective disagreement between the "reviewer" and the "reviewed" has been a recognized weakness in this audit program from its inception.

B. Changes in Medicaid

Many of the Medicaid changes in H.R. 1 were adopted to reduce costs; the mounting costs of that program have certainly made it clear that genuine efficiency and economy is very much in order.

However, certain provisions of H.R. 1 have raised questions about the possibility of a "boomerang" effect: short-term reductions in cost, but an ultimately higher price-tag.

Section 207, for example, requires that the Federal fund matching for patients must be reduced by one-third after each patient has been in a hospital, skilled nursing home, or intermediate care facility for 60 days (90 days in the case of a mental hospital). The cutbacks will apply only if States do not have effective utilization review programs. However, less than half of the States have effective programs in operation at the present time, according to the General Accounting Office. In the short run this will mean some Federal dollars will be withheld from some patients. The exact number of these patients is difficult to compute but the Department of Health, Education, and Welfare projects a $162 million "saving" because of this amendment.

While the intent of this provision is clearly to stimulate the States to establish utilization procedures, the patients who are caught in the middle of this struggle might be adversely affected. If they are arbitrarily moved to a lower level of care without proper testing to determine their needs the ultimate effect may be that the condition of these patients will deteriorate to the point of needing intensive nursing care or hospitalization.

H.R. 1 also requires States which cover the medically indigent to impose monthly premium charges under their Medicaid program. Moreover, the new law permits States to subject the medically indigent to deductible and copayment costs. If States do so, as seems likely, two things will happen: (a) the copayment and deductibles will constitute disincentives to the use of the Medicaid program by the poor, and (b) the Federal Government will save $89 million, according to HEW estimates.

Section 225 states that if nursing home rates are raised by the State to more than 105 percent of the previous year's rates, Federal matching funds will not be available. This is an arbitrary Federal ceiling on nursing home rates intended to save the Federal Government $22 million.

Section 231 removes an important Medicaid provision which required States to maintain their current level of expenditure in Medicaid. In effect, the States were barred from backing out of their commitment to the aged, infirm, blind, and disabled. They were perfectly free to spend more money but not less than what they spent last year. In spite of the efforts of Senator Edward M. Kennedy and Senator Frank E. Moss who offered an amendment to delete section

231 and retain the "maintainance of effort" requirement, the provision was adopted.

Another valuable provision that was lost was the requirement for States to establish comprehensive Medicaid programs by 1977. The effect of this measure was to direct States to move beyond certain mandatory services under Medicaid: in-patient hospital care; out-patient hospital care; laboratory and X-ray services; early and periodic screening, diagnosis, and treatment of mental defects of eligible persons under 21, and family services and supplies; and physician services. In addition, home health services are required for persons eligible for skilled nursing facility care. However, the Kennedy-Moss effort to block H.R. 1's repeal of the comprehensive Medicaid requirement failed on the Senate floor.

Section 246, which unifies Medicare and Medicaid standards, is a mixed blessing. Almost all advocates in the field of long-term care have suggested the need for a single set of standards for Medicare and Medicaid nursing homes and likewise for unified inspection procedures. Both programs, after all, provided "skilled nursing"—Medicare with rather precise definitions of what that meant and Medicaid with 50 different definitions. The 1972 Social Security amendments (formerly H.R. 1), use the Medicare definition of "skilled nursing" care augmented by certain of the Medicaid standards, specifically, the Moss amendments of 1967. In essence, the programs have been unified with the higher standard retained wherever a reconciliation was necessary. These assumptions from the reading of the law will no doubt be clarified by regulations. However, the interaction of the negative provisions of H.R. 1 and the new intermediate care facilities regulations (also subject to change) could be negative and far-reaching.

II. THE ICF ISSUE

Intermediate care facilities (ICF's) are—as the name suggests—intended to help those who do not need around-the-clock nursing care and other mandatory services provided by a "skilled" nursing home.

The demand for ICF's arose when surveys indicated that many patients in nursing homes did not need such high-level care; they needed, first, a roof over their heads, and, second, some help from medical and other personnel to get them through each day. They were not well enough for "independent living;" they were not ill enough for expensive, around-the-clock nursing care.

Therefore, the argument goes, let us develop a less expensive, but adequate alternative: the ICF.

A. Evolution of ICF'S: 1967–73

Congress first acted on ICF's in 1967, when it passed Senator Miller's measure to establish a new level of Federal-State benefit payments for ICF care. This legislation (section 250 of P.L. 90–248) did not amend Medicaid law. Instead it made possible direct payments (under title XVI of the Social Security Law) for the care of persons in ICF's.

Several controversies complicated the first few years of ICF's. Regulations were proposed in June 1969 which required minimum Federal standards. Under pressure from State health departments,

HEW reevaluated these regulations and the 1967 Miller amendment. With this second look HEW ruled that the statute as passed did not provide the basis for Federal regulation. Accordingly, the new regulations published in June 1970, allowed the States to promulgate their own standards. In short, ICF regulation became totally a State responsibility.

Action in the Congress: The Senate Finance Committee had voiced its concern about the administration of the ICF program as early as February 1970, when it condemned the "wholesale transfer" of patients to the lower level of ICF care.

The Finance Committee then proposed to transfer the ICF program from its cash grant status under title XVI of the Social Security Act into title XIX (Medicaid), thus providing a base for adequate Federal regulation. The committee wanted to require the Secretary of HEW to set minimum Federal standards. After several unsuccessful attempts, this plan was finally adopted as Public Law 92–223 on December 28, 1971. Regulations, however, were not issued until March 5, 1973.

ICF's the Central Problem: From the very beginning, students in the field of long-term care have realized the need for a nursing home benefit, covering "more than room and board and less than skilled nursing." However, there have been fears that the implementation of such a benefit without accompanying controls and protections would result in dumping of individuals from skilled nursing homes to the lesser level (ICF care) not out of patient need but simply to save money.

Fears about the "dumping" issue were intensified in March 1972 when California began an extensive program to transfer patients from State hospitals and nursing homes into ICF's at the rate of about 1,000 patients a month. An investigation led by California Senator Anthony Beilenson led to the introduction of his resolution in January 1973 calling for a moratorium on transfers "pending the enactment of legislation to prevent precipitous and ill-advised transfers." The Senator also told the Los Angeles Times [5] that the State Department of Health had provided no data to allay his fears that patients were being discharged without medical evaluations, against the wishes of their families *and their physicians.*

The ICF Regulations: Senator Moss welcomed the ICF regulations because they finally would give some control over what had been an administrative no man's land. Moreover, the regulations incorporate the Senator's bill, S. 2934, making the fire safety provisions of the Life Safety Code applicable to ICF's. However there is still room for improvement in the following areas:

1. There are no separate standards for the mentally ill and the physically ill patients, and no mention of possibly adverse effects of "mixing" senile with sane, but physically ill, patients.

2. The personnel standard requires the services of only one LPN per day [6] and employs "sufficient numbers" language instead of specific ratios. Although there are some ratios with respect to the mentally retarded they are hardly high enough.

[5] The Los Angeles Times, July 5, 1972, reported that 32 patients had died within a short time after they had been classified as not ill enough to need skilled nursing home care and transferred. (Reprinted in "Trends in Long-Term Care", part 20, p. 2523, Aug. 10, 1973. Hearings by the Subcommittee on Long-Term Care of the Senate Special Committee on Aging.)

[6] Four hours consultation with an RN is required weekly.

Specifically, for patients that are most difficult to handle those "severely or profoundly retarded, moderately and severely physically handicapped, and residents who are aggressive, assaultive, or security risks, or who manifest psychoticlike behavior, a minimum staff to patient ration of 1 to 2." This is the highest ratio promulgated, and it is actually below the national average of what nursing homes currently provide, 0.6 personnel per patient as compared to 2.6 personnel for every patient in hospitals.[7]

3. The standards use the "in substantial compliance" language which haunted the Medicare program. The language permits the licensing of facilities with deficiencies. HEW seeks to guard against the State's overuse of this "super-waiver" category by limiting their contracts to a total of two 6-month periods or 12 months. However, in the area of sanitation and environment, deficiencies can exist under the regulations for up to 2 years.

4. As has been mentioned, the fire safety standards incorporate the Life Safety Code of the National Fire Protection Association which makes the ICF program consistent with Medicare and Medicaid's existing programs. This action was proposed by Senator Moss as S. 2934 following the September 15, 1971, Lil Haven Nursing Home Fire (an intermediate care facility) in his home State of Utah where six people died. However, the regulations provide generous waivers once again. With the single precaution that the State certify to HEW that exempting a facility from some of the provisions of the code will not jeopardize the lives of patients, then, a waiver of the code provisions can be allowed (presumably without time limit) if: (a) "the structural changes in the facility are of such magnitude as to be infeasible or economically unpractical"; or (b) "if the provisions of the Code rigidly applied would result in unreasonable hardship on the facility."

5. A consistent pattern in the regulations has been demonstrated by the treatment of the fire safety regulations above. Similarly, requirements with regard to social workers, dietitians, therapists, recreation and activities begin with the implied suggestion that dietitians should be on the ICF's payroll but then resort to language such as "a designated staff member suited by training and experience." Applying this analysis, to the dietary critera, the implication is that almost anyone who has been a cook anywhere, anytime, and anyplace can meet this requirement. As a saving grace, HEW suggests the necessity of "consultation with a dietitian."

6. This same kind of attitude is seen in the standards for the mentally retarded. The regulations require a qualified professional who is to be responsible for the implementation of each resident's plan of care and services. Thus, the least expensive and most available individuals may be employed to meet this standard. Moreover, the standards specifically state that before the mentally retarded can be restrained there must be written orders from the qualified professional. The implication is that a social worker or speech pathologist can order restraints.

[7] "Developments in Aging 1970," A Report of the U.S. Senate Special Committee on Aging, March 24, 1971, S. Rept. No. 92-46, p. 41.

Also with regard to the mentally retarded. there is a provision which allows the waiver of life safety code if "in the opinion of competent medical authority" residents are capable of exercising average judgment in taking action for self-preservation under emergency conditions." Just what "average judgment" means in the context of the mentally retarded is difficult to say.

Interrelationship: H.R. 1 and the New Regulations: As already stated, H.R. 1 unifies Medicare and Medicaid standards. In every case where a reconciliation has been necessary the higher standard has prevailed. In addition, the Medicare definition of skilled nursing has been retained.

This change can be hailed as a major step forward, since standards will be raised and there will now be only a single set of inspections.

But even as the new standards are being celebrated, the question arises: Will the imposition of the higher Medicare standard, with its restrictive definition of skilled nursing, mean wholesale transfers of patients from skilled nursing homes into ICF's?

The urgency of this question may be measured by the estimates of the number of Medicaid skilled nursing patients who could not meet the present Medicare definition. *Those estimates range from 2.5 percent to as high as 81 percent.*[8]

If large-scale transfers do take place, patients will be moved to facilities where, as mentioned earlier, present standards require only one licensed practical nurse and "sufficient numbers of personnel."

Moreover, former mental patients and individuals with tuberculosis, cerebral palsy, or epilepsy may be housed in these facilities with the infirm elderly. The result could have a favorable effect on State budgets but a damaging effect on the individuals.

On the other side of the coin, advocates argue that the provisions for medical review, utilization review, and professional review are intended to make certain that patients are placed in the appropriate level of care.

It should be noted that the ICF regulations discussed earlier in this chapter refer to inhabitants as "residents" and not as "patients"—although it can reasonably be expected that some very ill individuals will be housed in ICF's, particularly if the skilled nursing definition is as restrictive as the Medicare definition had been.

But the situation may be even more serious. If skilled nursing is narrowly defined and if the ICF standards are stringently applied, the effect in the short run may be to decrease further the available facilities in many States, particularly those having policies underway to transfer individuals from mental hospitals into less expensive community facilities. This shortage of facilities or simply the desire to save costs may cause States to (1) not enforce standards, or (2) house individuals in rest homes, boarding homes, or unlicensed nursing homes.

Many of these lesser facilities are known as "bootleg" nursing homes in that they serve the function of nursing homes but do not have to meet the rigid standards. Moreover, the source of funding has been independent of Medicare and Medicaid.

Recent fires in Honesdale, Pa., and in Rosecrans, Wis., brought this practice out into the open. In Honesdale where 15 patients died,

[8] See, General Accounting Office Audit, May 28, 1971.

the State of Pennsylvania was found to be using Old Age Assistance (title I, Social Security Act), funds to support individuals in what the State called a "skilled nursing home". In reality, it was little more than a boarding home. Title I typically provides a cash payment to individuals who are free to find their own housing. As practiced in Pennsylvania, individuals were given a cash payment under title I but placed in specific facilities. A similar pattern emerged in Wisconsin where nine older Americans died. Seven of the home's residents were supported by Old Age Assistance funds; three actually needed skilled nursing as determined by a State nurse the day before the fire.

The title I funds have been used to good advantage by States for individuals discharged from State mental institutions. Since the average cost of care in a State hospital might be $750 per month and the cash payment under old age assistance $150 (half Federal money), the temptation is great.

Experts are divided on whether section 249(D) of H.R. 1 will inhibit or prevent this process. The section prohibits the use of cash assistance payments for individuals who could be cared for under the Medicaid program. Since H.R. 1 "federalized" the Old Age Assistance program and provided a minimum $130 floor per month, some States may be tempted to define individuals outside of the Medicaid program to take advantage of totally Federal reimbursement.

Somewhere in this struggle over dollars, with changing programs and new enforcement tools on the part of the Federal Government and with the States changing the labels of patients from "skilled" to "intermediate" or from "mental" to "ICF patient," the real needs of individuals may be forgotten.

As a fundamental premise the patient's needs should determine his placement. Ideally, those needs should be first met in his own home with institutionalization offered only in extreme situations. This decision should not be determined solely by medical judgments; rather, functional ability should be the touchstone of programs developed for the infirm elderly.

III. FORTHCOMING REPORT: TRENDS IN LONG-TERM CARE

This chapter on long-term care will not offer specific recommendations, as is usually the case in annual reports of the Senate Special Committee on Aging.

Those recommendations have been deferred to more extended treatment in a special report—soon to be issued—which will summarize hearings and other forms of inquiry which began in December 1963, when this committee's Subcommittee on Long-Term Care was established. Under Chairman Moss, the subcommittee conducted a series of hearings culminating in 1967 with enactment of the Moss amendments which substantially upgraded the quality of nursing home care in the United States.

In July 1969, however, hearings were resumed with testimony on what Senator Moss described as the "weak and watered down" implementation of the Moss amendments by the Department of Health, Education, and Welfare. In his second hearing (January 1970), he described issues to be examined:

These hearings conducted by the Special Committee on Aging of the U.S. Senate are for the purpose of setting forth problems that exist and situations that occur in the various parts of the country and affect the various people. They will enable us, when the record is all completed and studied by our committee, to take the necessary steps we can take to remedy the deficiencies that have occurred or to perhaps move on into other fields where legislative action may be required.[9]

* * * * * * *

He also stated earlier:

Inevitably we must deal with problems and unfortunately we sometimes give the impression that there is nothing positive in the nursing home industry. Nothing could be farther from the truth. We seek examples of America's finest nursing homes that can be used as models for the future.[10]

* * * * * * *

The hearings were to focus on several important, current questions including:

—the shortage of nursing personnel;
—Medicaid reimbursement rates;
—the national trend of nursing homes to drop out of the Medicare program;
—cost and delivery of services;
—guardianship and protective services;
—the relationship between the hospital and the nursing home;
—the nursing home as a business;
—access of minority groups to nursing homes;
—overbuilding in some areas and a lack of an overall planning; and
—rehabilitation of patients.

Hearings since that time have dealt with the topics mentioned by Senator Moss and also have dealt with specific problems which arose suddenly, such as a salmonella epidemic, fatal fires, or scandals of mismanagement and outright profiteering.

The subcommittee has, however, attempted to emphasize positive aspects of nursing home care as well as the tragic or the abhorrent. The subcommittee has also attempted to help point the way toward a national policy of rational, humane treatment of the infirm elderly. It must face the fact that the average cost of a nursing home per month is near $500 and the average Social Security income for a retired couple is less than $300. It must face the fact that conservative estimates indicate that one out of five—or 4 million—older Americans have a need for nursing or other personal care services. It must face the fact that much-vaunted "alternatives to institutions" are not yet available on the scale needed.

With more and more individuals living longer and longer, such facts may become harsher—unless we face up to the problems of the present. The forthcoming report will provide one estimate of those problems, and it will give its recommendations for dealing with them.

[9] "Trends in Long-Term Care", hearings by the Subcommittee on Long-Term Care, Part 2, St. Petersburg, Fla., Jan. 9, 1970, p. 149.
[10] Dec. 29, 1969, press release for St. Petersburg hearing.

CHAPTER V

HOUSING: REFORM OR CHAOS?

A mood of uncertainty dominates the field of housing and community development early in 1973 as cities, organizations, and citizens try to continue their struggle for better housing and renewed communities.

Their concern is caused largely by the Nixon Administration announcement in January of a major curtailment of community development programs.

Three words summarize this departure from previous policy: termination, moratorium, and impoundment.

The Administration plans to terminate seven categorical Community Development Programs this year. Terminated as of January 5, 1973, are: Open Space Land, Water and Sewer Facilities, and Public Utility Loans. Scheduled for termination on June 30, 1973, are: Model Cities, Neighborhood Facilities, Rehabilitation Loans, and Urban Renewal.

Also effective January 5, 1973, is a moratorium on all new commitments for subsidized housing, including public housing. Many projects on the verge of breaking ground with years of planning behind them now find themselves floundering with no indication of when, or if, they will be rescued.

In addition, funds for two of the most important programs for housing older persons are now impounded. In its latest budget report, the Administration reports that the following amounts remain unused: $171.5 million for the Section 236 program and $38.6 million for Rent Supplement.[1]

Accompanying these policy changes are a new philosophy, a proposed new structure, and a new Secretary.

The new Secretary for Housing and Urban Development is James T. Lynn who, at the same time, will fill one of the supercabinet posts recently proposed by the President. In addition to his duties at HUD, he will coordinate *all* Federal programs in the fields of housing, transportation, and community development.

The President's new domestic strategy, with its emphasis on controlling the economy and assigning the primary responsibility for the solution of social problems to the State and local governments, has direct bearing on Federal housing and community development policy. The President has suggested that the seven categorical programs planned for termination (see above) be absorbed into the Special Community Development Revenue Sharing program scheduled to begin July 1, 1974.

In addition, the Administration asserts that the frozen or curtailed programs "have not produced results commensurate with the costs to the taxpayer." [2]

[1] Appendix, Budget of the United States Government (fiscal year 1974), pp. 476-477.
[2] Ibid., p. 475.

Deeply affected by these new directions and abrupt terminations are programs that have a major impact on efforts to provide decent housing at a reasonable price for needy older Americans.

I. HOUSING FREEZE: EFFECT ON THE ELDERLY

Effective at the close of business on January 5, 1973, new commitments for subsidized housing programs were brought to a halt that could last as long as 18 months. This moratorium includes three programs which provide housing for older persons: the interest-subsidy program for rental housing (Section 236), public housing, and the rent supplement program.

The housing freeze does not mean that all construction of new units has come to a complete stop. Units under preliminary loan contract in public housing and units with approved feasibility in FHA-assisted programs (including 236) can proceed to construction in the coming months. In a letter[3] to Senator John Sparkman, Kenneth R. Cole, speaking for the President, assured that subsidized housing starts would continue at an annual rate of about 250,000 for the next 18 months. While this level of production is not far below the rate for the previous 12 months, it is down considerably from the fiscal year 1972 construction level of 322,025.

The January 5 moratorium created a further stumbling block in attempts to meet the original 10-year housing production goals set in 1968. By 1978, 6 million subsidized housing units were to be constructed under Federal programs. Including fiscal year 1974 budget projections, production levels will fall 45 percent behind this goal.[4]

While the Administration claims that subsidized units will continue at the rate of 250,000 per year, it is not clear how many of these units will be designed for the elderly. Previously, 40 percent of public housing units were being built for the elderly and 15 to 20 percent of Section 236 units were reserved for older persons. The Department of Housing and Urban Development (HUD) has not released any figures to indicate how many units for the elderly escaped the freeze or how many fell victim to it.

The freeze accompanies two important developments that have had serious effect on the older person's budget: the end of rent control and the skyrocketing cost of food.

Since the end of Phase II rent controls, rents of many elderly tenants have been increased markedly. For example, a Washington, D.C., widow was notified in February 1973, that her rent was going up 75.3 percent, from $77 per month to $135 per month. Her sole monthly income is a $141 Government pension check which must cover rent, two utility bills and two meals each day for herself and a dependent brother.[5]

High food prices became an increasingly urgent national issue in 1973. Wholesale prices jumped 1.6 percent in February (an annual rate of 19.2 percent if it should continue). This jump was led by a 3.2 percent rise in farm products and wholesale food prices.

[3] Date of this letter: Jan. 15, 1973.
[4] Journal of Housing, No. 2, February 1973, p. 69.
[5] *Washington Post*, Mar. 18, 1973, p. B1.

Since shelter and food are the two highest items in the average elderly person's budget, older Americans are increasingly aware of the need for housing projects designed for the low and moderate income elderly. The news of the housing freeze has therefore been intensely disappointing and frustrating.

As an illustration, the Housing Authority of Norwalk, Conn., has in process a 54-unit elderly housing project which includes a 5,000-square-foot senior center. The housing authority has 600 eligible elderly persons on its waiting list with only 210 occupied units. Groundbreaking was to begin in February 1973, on this project, and the local community had raised $35,000 to help pay for the senior center (including raffles, cake sales, and Bingo parties). The housing authority receives frequent calls after applicants have checked the obituary column and found a vacancy has occurred. One applicant even offered a part of his Social Security check to a member of the staff. HUD has stopped the processing of this project.[6]

II. PRODUCTION STILL FAR BEHIND NEED

Production of housing for the elderly has not reached the level of 120,000 per year as recommended by the White House Conference on Aging, but the Department of Housing and Urban Development does report that 70,385 units were authorized during fiscal year 1972.[7]

Projected figures for fiscal 1973 are uncertain because of the moratorium. HUD also reports that the cumulative number of "specially designed" multifamily dwelling units now totals 452,414. This total includes units occupied, under construction and approved as of December 31, 1972:[8]

Multifamily housing for the elderly (cumulative)

Public housing [1]	348, 730
Section 202 [2]	45, 494
Section 236 [3]	[6] 21, 832
202–236 conversions [4]	27, 488
Section 221(d)(3) [5]	[6] 8, 900
Total	452, 414

[1] This program is administered on the local level by Local Housing Authorities pursuant to policies determined by HUD consistent with the Housing Act of 1937 when public housing began.

[2] Section 202 of the Housing Act of 1959 established a program of direct Government loans at 3 percent over a 50-year period to nonprofit sponsors to construct apartment units for moderate-income elderly.

[3] Section 236 of the Housing Act of 1968 established an interest-subsidy program for multifamily housing construction. The owner or sponsor pays off a loan as low as 1 percent and the Federal Government pays the interest difference between 1 percent and the interest charged by the financing agency.

[4] In 1970, HUD determined that all remaining 202 applications would be funded under the Section 236 program, thus creating the 202–236 "pipeline."

[5] Section 221(d)(3) of the National Housing Act began in 1961. Under this program sponsors (Non-profit, cooperative, or limited-dividend) were given below-market interest rate 40-year mortgage loans to build multifamily buildings for moderate-income families. Today, the program only provides insurance for the mortgage.

[6] These figures include only fiscal year 1972 approvals.

[6] Letter to Senator Harrison A. Williams, Jr., from Mr. Lawrence Hochheimer, Municipal Representative for the Elderly, and Mrs. Barbara Andrews, Chairman of the Norwalk Housing Authority, Feb. 16, 1973.

[7] See p. 176, Annual Report to the Senate Special Committee On Aging, Department of Housing and Urban Development, 1972 Highlights.

[8] Ibid., p. 176.

A. Public Housing

Since the Brooke amendment [9] became effective, and limited the maximum rent in public housing to 25 percent of a tenant's income, local housing authorities have relied more and more on operating subsidies from HUD to meet their added expenses. Because the Brooke amendment went into effect with very few controls, the demand for subsidies increased tremendously in a very short time. This demand was accelerated by rising costs for maintenance. In 1972, the Office of Management and Budget (OMB) put a lid on the "open ended" approach to operating subsidies. The Administration request for operating subsidies was $170 million for fiscal year 1973 when most estimates of the need were over $300 million.[10] As a result some housing authorities were on the brink of bankruptcy for the later part of the year. On December 1, 1972, OMB released an additional $100 million to be disbursed on the basis of a new "interim formula." While this announcement provided some breathing room for hard-pressed authorities, most public housing programs are still severely strapped for adequate funding.

SERVICES CUT BACK

Many housing authorities have been forced to cut back in their service programs for the elderly as the result of this tightened "interim policy."

In addition, the $2.5 billion ceiling placed on the social service programs under the Social Security Act has added to the problem. (See Chapter VII for additional details.) Combined with this ceiling, the new requirement that 90 percent of allocated Federal matching dollars be spent on current welfare recipients (Old Age Assistance, in this case) has brought some service programs to a halt.

For example, after years of planning by the Allegheny County Housing Authority (surrounding Pittsburgh) and the Pennsylvania Department of Public Welfare, the Ancillary Services program for elderly tenants was terminated on December 31, 1972, after 15 months of operation.[11] This program was servicing over 2,300 elderly citizens of Allegheny County living outside the City of Pittsburgh. While these tenants are by no means affluent, 90 percent are considered to have incomes over the $1,632 cutoff figure for Pennsylvania Old Age Assistance.

In some cases, HUD policy threatens new construction. Despite the general success of public housing projects exclusively for the elderly, HUD financial feasibility requirements have occasionally stopped the approval of new projects for older persons.

A HUD directive of December 29, 1971 (Circular 7475. 1 Supp. 3) established a new financial feasibility test for all new public housing projects. This test requires that routine expenses for the project (administration, operation, and maintenance) not exceed 85 percent of the rent to be charged.

[9] Section 213 of the Housing Act of 1969, amending Section 2(1) of the Housing Act of 1937.

[10] See statements of Senator Javits and Senator Brooke, Congressional Record for June 14, 1972, page S 9375–9376.

[11] Letter of Mar. 23, 1973, to Senator Williams from James W. Knox, Executive Director, Allegheny County Housing Authority, in response to a survey being conducted by the Senate Special Committee On Aging to determine the effects of the housing freeze.

The National Capitol Housing Authority in Washington, D.C., reports to the committee that it has not been able to meet this financial feasibility test since it became effective. To meet the test in Washington, D.C., tenants would need an average yearly income of over $3,000. The waiting list for elderly units numbers approximately 1,500 in Washington, and a recent analysis of the income levels of persons on the waiting list revealed only 15 households with incomes over $3,000.

Not all housing authorities are threatened by this requirement, but it is another example of budgetary policy that can have serious repercussions in the development of new housing for the elderly. Unless HUD is willing to make certain exceptions for elderly projects, the Administration's economy moves—such as the financial feasibility test—may soon make new public housing for older persons less and less feasible.

All new commitments for public housing are now frozen during the moratorium. Unlike other subsidy programs that have unused contract authority impounded by the Administration, the public housing program has no unused authority. New congressional authorization will be required if new commitments are to be made

B. Section 236 Interest-Subsidy Program

Second only to public housing, the Section 236 program (see footnote 3 to table, p. 44) has been the major vehicle for production of subsidized housing for the elderly. In fiscal year 1972, 21,832 units for older persons were approved for construction under 236. Units for the elderly were not identified in the 236 program prior to this year, so figures for earlier years are not available.

This program provides an interest-subsidy to the mortgagee rather than a direct loan of the full amount to the sponsor, and thus, the 236 program has less impact on the annual Federal budget than the 202 program does. In the long run, however, the costs multiply as more projects receive subsidy obligations that stretch over 40 years. The ballooning cost of this program was one of the reasons new commitments were halted. According to the Administration, $171.5 million dollars in Section 236 funds have not been utilized.[12]

C. Rent Supplement

The Rent Supplement program has suffered from underfunding since its beginning in 1965. The Administration's budget request for fiscal year 1973 was a low $48 million and $5.9 million of that figure was earmarked for the elderly for 4,700 units. According to the Administration, and as part of the housing freeze, they are holding back $38.6 million for Rent Supplement.[13]

D. Section 202

Still officially part of Federal housing law, the Section 202 program (see footnote 3 to table, p. 44) nevertheless continues to lie idle. Despite attempts to revitalize this program last year,[14] the Administra-

[12] Appendix, Budget of the United States Government (fiscal year 1974), p. 477.
[13] Ibid., p. 476.
[14] Senator Williams proposed and the Housing Subcommittee of the Senate Banking, Housing and Urban Affairs Committee accepted a $100 million increase in the appropriation for Section 202 raising the total from $650 to $750 million. This increase became part of S. 3248 which passed the Senate on Mar. 2, 1972. The bill later died in the House Rules Committee.

tion has folded 202 into the Section 236 program (202-236 conversions) and is not accepting any more applications for 202.

Although the Section 202 program was popular and successful, it was unpopular with the Administration because of its impact on the annual Federal budget. The program was financed through direct loans of the *full* amount of the mortgage to the sponsoring agency to be paid back at 3 percent. The Section 236 program, instead, requires only that interest subsidies be paid to supplement the mortgage for each year.

It is significant that a recent report of the Joint Economic Committee [15] suggests that a direct loan approach would save the Government $2 to $4 billion over the next 6 years in interest costs to finance Section 235 (homeownership) and Section 236.

E. Sections 231 and 221(d)(3): Unsubsidized Programs

Two other programs still provide some assistance to housing the elderly, but on a very small scale. Neither of these programs offers any subsidy, only insurance for the mortgage.

Over 49,000 units for the elderly have been approved under the Section 231 program. This program has had many failures and foreclosures and has slowly been reduced in size. In fiscal year 1972, only 775 units for the elderly were approved.

Originally, the Section 221(d)(3) program (see footnote 3 to table, p. 44) did provide a subsidy in the form of a below-market-interest-rate loan from the Government. Today, the program is still alive but offers only insurance on the mortgage. Nevertheless, this program has been a major vehicle for the rent supplement program, and 8,900 units were approved for fiscal year 1972, some with rent supplement. This program is caught in the freeze, and figures are not available to assess how many units have received approval.

III. URGENT ISSUES

A. New Problems in Fire Safety

Recent tragic events have focused a great deal of national attention on the dangers of fire in highrise buildings. Of special concern was the fire in Atlanta, Ga., that took the lives of 10 elderly residents. The fire occurred in Baptist Towers, a project built under the Government's Section 236 interest-subsidy program. To explore this issue in more detail, Senator Harrison A. Williams, Jr., held hearings before his Subcommittee on Housing for the Elderly on February 27 and 28, 1973.

Because Baptist Towers is a modern fire-resistive structure, the Atlanta fire led a representative of the National Fire Protection Association to call it "one of the most significant fires to occur in a residential occupancy in recent times."

[15] "Housing Subsidies and Housing Policy", Report of the Subcommittee on Priorities and Economy of the Joint Economic Committee, Mar. 5, 1973, at p. 8. The report says, "The Congress should establish a subsidized Housing Loan Fund from which direct loans could be made to finance Section 235 and 236 housing in order to save between $2 and $4 billion in interest costs over the next 6 years. It should be noted that such loans shall be recorded in government accounts in a separate budgetary capital account, excluding them from regular budgetary outlays."

Several experts testified that characteristics of older persons could affect their safety in a fire emergency. Elderly tentants of a highrise building, for example, normally utilize the elevators and seldom the stairways. In a serious fire, the elevator can be very dangerous for it will often be drawn to the floor of the fire and stay there. Older persons are often not familiar with the stairwell exists that are usually the only means of evacuation. The elderly are also more susceptible to the effects of fire and smoke. Physical disabilities affecting sight, hearing, and mobility can also produce obvious handicaps in escaping a fire danger.

Additional information about the Baptist Towers tenants on the 6th through 11th floor was provided by a survey conducted after the fire by the Atlanta Fire Department and the National Fire Protection Association (NFPA). The fire originated on the seventh floor. Of the 95 persons interviewed, the average age was 71. Nearly 25 percent of the tenants interviewed had physical impairments which conceivably could affect reactions to an emergency situation.

Expert witnesses concentrated their recommendations in three areas: automatic detection and warning systems, automatic extinguishing (sprinkler) systems, and systems designed to contain a fire to its point of origin. Several witnesses also supported the need for a "systems" approach.

Mr. Richard Bland, Chairman of the National Commission on Fire Prevention and Control, testified:

> I submit to this Subcommittee on Housing for the Elderly that the requirement of complete automatic sprinkler systems is the available technical solution toward control of fire in housing for the elderly.

Sprinkler systems received other strong endorsements, but they are expensive. And the cost issue is especially important in any housing program designed to produce rental units at a price that low- and moderate-income elderly can afford.

Other witnesses advocated the use of automatic smoke detection systems that would detect the "products of combustion" in the air. This system is generally cheaper to install than complete sprinkler systems and can detect products of combustion before flames appear and sometimes before actual smoke can be seen.

In response to the growing concern over fires in tall buildings, the Department of Housing and Urban Development (HUD) has sent to the field for comment proposed new regulations to stiffen the requirements for fire safety in all elevator buildings.[16] Briefly summarized their new standards include:

(1) Automatic sprinklers in all corridors, public spaces, service and utility areas;

(2) An automatic smoke detector and alarm system within each living unit;

(3) Automatic door closers;

(4) Compartmentalization: at least two fire divisions per floor; and

[16] The regulations were sent to the industry representatives on Jan. 20, 1973, and were published in the Federal Register on Mar. 3, 1973.

(5) Smoke detectors in each elevator lobby that will program the elevator to bypass a floor where the detector has been activated.

These new proposals do not include a requirement for the alarm system to transmit automatically the alarm to the nearest fire department, a requirement that HUD estimates would cost $200 per building.

The new HUD proposals are a distinct improvement over current regulations, but they apply only to new construction. There remains a serious need to develop a way to help existing buildings, and those already approved, to incorporate better fire safety systems.

Buildings with a completely automatic sprinkler system can afford to make "trade-offs" on other fire safety requirements. In fact, some experts say that "trade-offs" can equal the cost of the additional sprinkler system in certain cases. The concept of requiring sprinklers and allowing trade-offs is still in its early stages of development and deserves careful study and early implementation.

The new HUD proposals do not offer the completely sprinklered building as an option and do not allow for cost trade-offs.

B. Security From Crime and Violence

The most recent crime statistics are revealing a decline in the general level of serious crime.[17] Unfortunately, the most violent types of crime—murder, rape, and felonious assault—have continued to climb. Most of the decline has been in the crimes against property: robbery, larceny, and auto theft.

This drop in the number of serious crimes is certainly a welcome sign, but no one is ready to declare our streets free from danger yet. Of particular concern is the plight of the elderly person, who still remains a most vulnerable target for the would-be criminal.

During 1972, the Williams Subcommittee on Housing continued its study of crime and the elderly with hearings in Washington, D.C., and Boston, Mass.[18]

Witnesses from several cities including Cleveland, Jersey City, Boston, New York, Baltimore, and Hartford, have described situations of constant fear where elderly tenants were afraid to leave their apartments at night or day, and where friends and relatives were equally afraid to visit. Directors of community service agencies serving the elderly told how the fear of criminal attack made delivery of their services impossible to many older persons.

Unfortunately very little data exists to assess how often the elderly person is a crime victim. Crime statistics traditionally have not considered the characteristics of the victim. Instead, the emphasis has been on the criminal and the type of crime.

[17] New York Times, Mar. 7, 1973, p. 1.

[18] Hearings by the Subcommittee on Housing for the Elderly, U.S. Senate Special Committee on Aging, "Adequacy of Federal Response to Housing Needs of Older Americans":
Part 4. Washington, D.C., Oct. 28, 1971.
Part 5. Washington, D.C., Oct. 29, 1971.
Part 6. Washington, D.C., July 31, 1972.
Part 7. Washington, D.C., Aug. 1, 1972.
Part 8. Washington, D.C., Aug. 2, 1972.
Part 9. Boston, Mass., Oct. 2, 1972.

Nevertheless, Jerris Leonard, Director of the Law Enforcement Assistance Administration (LEAA), testified:

> LEAA recognizes the possibility that the elderly may experience special crime problems when inhabiting public housing in high-crime districts.[19]

The New York City Housing Authority is one of the very few authorities that keep crime statistics that do indicate characteristics of the victim and even the exact location in the building where the crime occurred. The experience in New York City public housing supports the conclusion of Mr. Leonard and indicates that the elderly are most vulnerable. In a letter to Senator Williams, Simeon Golar, Chairman of the New York City Housing Authority, reports:

> We maintain careful data regarding crime in our public housing developments . . . crimes against the elderly occur at twice the rate as against other residents of public housing.

HUD POLICY

The Conference Report on the Housing and Urban Development Act of 1970 authorized operating subsidies to "* * * achieve and maintain adequate operating and maintenance services * * *" which could include "* * * guard and other costs relating to the physical security of project residents * * *."[20]

While not denying the existence of this language, HUD has been far from generous in its commitment to help local authorities with their crime problems. HUD policy in this area is spelled out in a HUD Circular issued January 18, 1972 (HM 7475.6), which states, "The police force of the locality, not the Local Authority, has the basic responsibility for the prevention of crime, disorder, and vandalism." This policy is based in part on a required cooperation agreement between the local housing authority and the local governing body which requires the city to provide the same level of police and other protective services to the housing projects as it does to other tenants. Unfortunately, in areas with bad crime problems the buck is often passed. The police say it is the authority's problem; the housing authority says it is a police responsibility; and the tenant may be left defenseless.

HUD does recognize the need for extra protective services under certain "abnormal conditions" where the level of police protection is insufficient to control the crime and vandalism.

Assuming there is a compelling need, where do the funds come from? This is the crux of the problem. HUD will allow the local authorities to spend part of their budgets on added security if their proposals are "reasonable, properly supported, and financially feasible (taking into account the availability of operating subsidy)".[21] Last year, because the Office of Management and Budget (OMB) withheld a large portion of the required operating subsidies until the end of the year, local authorities were extremely hard-pressed to perform routine maintenance procedures, much less begin an active security program.

[19] Hearings by the Subcommittee on Housing for the Elderly, U.S. Senate Special Committee On Aging, "Adequacy of Federal Response to Housing Needs of Older Americans," Part 8, Washington, D.C., Aug. 2, 1972, p. 504.

[20] Senate Report No. 91-1216 to accompany S. 4368, the Housing and Urban Development Act of 1970, prepared by the Committee on Banking and Currency, Sept. 21, 1970, at p. 16.

[21] HUD Circular (HM 7475.6), Jan. 18, 1972.

Because HUD remains reluctant to earmark specific funds for security purposes, local authorities (with their extremely inflexible budgets) are forced to search for outside sources of money if they wish to put any kind of protective service program into operation. Among the other sources are the Law Enforcement Assistance Administration (LEAA), Model Cities, the HUD Modernization program, local city budgets, and the Emergency Employment Act.

TERMINATION INTENSIFIES THE PROBLEM

Prospects for the coming year are not encouraging because three of these programs are being brought to a halt, thus drying up three important sources of funds for security.

The public housing modernization program is scheduled for suspension as of June 30, 1973. Primarily, this program is intended to provide funds for capital improvements for public housing projects. Salaries for security personnel are not provided, but design modifications, hardware, lighting, and other valuable aids to security are authorized.

Under the Emergency Employment Act (EEA), salaries for guard services were available for public housing security programs. Kansas City, Mo., and Jersey City, N.J., utilized this program. The Administration's fiscal 1974 budget proposes to phase out the $1.25 billion EEA program altogether.

Finally, on June 30, 1973, the Administration plans to terminate the Model Cities program. A few housing authorities had obtained some security funding from Model Cities budgets.

NEW TECHNIQUES IN VIEW

Possible termination of three sources of funding for security is especially difficult to take as new security techniques take shape. The Center for Defensible Space Design in New York under the direction of Oscar Newman has recently finished a report for HUD entitled: "Immediate Measures for Improving Security in Existing Residential Areas". This manual provides a detailed explanation of the newest concepts in design, hardware, electronic security systems, and personnel. Five actual case studies illustrate how these various components interact, and how they can be used to supplement each other.

Mr. Newman has also reported to the committee that crime inside highrise buildings for the elderly can be reduced as much as 100 percent. By hiring a doorman and restricting entry to the building to one portal that is easily controlled visually, unwanted persons can be kept out. The provision of an alarm system that would summon the police automatically serves as a good backup device should someone push his way past the doorman into the building.[22]

In commenting on the security needs of the Boston Housing Authority, Leo Gulinello, a member of the Boston Police Department assigned to help with security in public housing, testified:

> One of the most frustrating experiences is to hold well documented security needs in one hand, and intelligent security suggestions as to how those needs could be met, in

[22] "Immediate Measures for Improving Security in Existing Residential Areas" by Oscar Newman, Barry Hersh, and Stephen Johnston, 1972, p. 5. See also *Defensible Space: Crime Prevention Through Urban Design* by Oscar Newman, Macmillan, 1972, p. 194.

the other hand, while all the time fully realizing, that the authority has no funds, to pay for an adequate security system.[23]

FINDINGS AND RECOMMENDATIONS

The Administration has begun a full reevaluation of Federal housing programs and housing policy based on their conclusion that the current program structure cannot possibly yield effective results even with the most professional management. They claim that the present programs have proven inequitable, wasteful, and ineffective in meeting housing needs.

Senate and congressional committees with the responsibility for housing legislation have reacted strongly to the housing moratorium and program terminations. While there is general agreement that improvements are needed, many congressional leaders are opposed to the abrupt nature of the cutbacks when nothing at all is being provided to take its place. Both Senator Sparkman, chairman of the Senate Banking, Housing and Urban Affairs Committee, and Representative Wright Patman, chairman of the House Banking and Currency Committee, have said they will hold hearings to reestablish the programs and save the workable parts. Senator Sparkman's Subcommittee on Housing held oversight hearings in early April, and he predicts early action on a housing bill in the Senate.

To assure that older Americans receive their full share of future housing programs the committee recommends that:

(1) Production of housing for the elderly be increased to 120,000 units per year.

(2) A special program be established to produce subsidized housing exclusively designed for the elderly. This program should be limited to nonprofit sponsors.

(3) An adequate portion of funds for other housing programs, such as public housing, should be earmarked for the elderly.

(4) An Assistant Secretary for Housing for the Elderly should be established at HUD to oversee at a top level all programs that affect older persons.

In addition the committee recommends that:

(1) Federal funding be earmarked to develop and pay for security systems at public housing projects faced with serious crime problems.

(2) An Office for Security and Crime Control be established under the Secretary for Housing Management at HUD.

(3) Minimum Property Standards be amended to allow alternative fire safety systems including completely sprinklered buildings with all possible cost trade-offs.

[23] Hearings by the Subcommittee on Housing for the Elderly, U.S. Senate Special Committee on Aging, "Adequacy of Federal Response to Housing Needs of Older Americans," Part 9, Boston, Mass., Oct. 2, 1972, p. 576.

CHAPTER VI

WHAT KIND OF OLDER AMERICANS ACT?

Congress acted in 1972 to raise the Older Americans Act to higher levels of funding, status, and effectiveness.

Funding levels would have quadrupled; the Administration on Aging would have finally been removed from the Social and Rehabilitation Service; a Federal Council on Aging would have been established; model projects would have concentrated on special problems of the elderly, such as housing and social services for the handicapped; and other steps would have been taken to improve services, training, and research.

The bill—as passed by the Senate and the House—adopted an Administration strategy to establish planning and service areas capable of mobilizing resources and programs within well-defined regions.

Months of hearings had preceded passage; the Administration was consulted again and again; and the bill had widespread support.

Nevertheless when the legislation reached the White House, President Nixon withheld approval—a "pocket veto" occuring after congressional adjournment.

Early in 1973, Congress acted on the bill once more. Some modifications were made to meet Presidential objections. Authorizations were pared down. A "Middle-Aged and Older Workers Training Act" was eliminated.

Finally, a compromise bill was approved unanimously by the House and Senate on April 18, clearing the measure (S. 50) for the White House.

On May 3, 1973, President Nixon signed P.L. 93–29, a comprehensive version of the Older Americans Services Amendments.

With this enactment, Congress has made it clear that it wants an Older Americans Act far more powerful than the one which existed in 1971, the year of the White House Conference on Aging.

I. EARLY PROMISE AND SETBACKS: 1965–71

Passage of the Older Americans Act in 1965 represented a major victory for the Nation's elderly. An Administration on Aging was established to provide a Federal focus to improve and enrich the lives of aged and aging Americans.

Service programs were created to help the aged to live independently in their homes.

Research and demonstration programs were authorized to test out innovative ideas to respond to many of the everyday problems confronting the elderly.

And funding for training was authorized to provide competent personnel to deliver services to the aged.

A. Congressional Intentions

From the very beginning though, it was readily apparent that the Older Americans Act represented a tenuous compromise. Its principal sponsors—Senator Pat McNamara and Representative John Fogarty—wanted a more powerful spokesman for the Nation's elderly.[1] But the Department of Health, Education, and Welfare—where AoA was ultimately placed—had opposed AoA's creation.

However, the legislative history of the act provided unmistakable evidence that Congress intended AoA to be a forceful and vigorous advocate on behalf of aged and aging Americans. To buttress this intent the Congress directed that the Commissioner on Aging be Presidentially appointed with the advice and consent of the Senate.

Committee reports made it abundantly clear that Congress expected AoA to be a high-level agency with the power and prestige to take action for older Americans. For example, the House Education and Labor Committee report had this to say:

> The Administration on Aging, headed by a Commissioner appointed by the President, subject to confirmation by the Senate, would have *coequal status with the Social Security and Welfare Administrations*. Thus, the older population would be meaningfully represented in the upper echelons of the Federal Government. (Emphasis supplied.)[2]

B. Low Funding Levels and Uncertainty About Mission

Limited funding requests, however, produced one of the major stumbling blocks for AoA to fulfill its responsibilities. During its first 7 years of existence, less than $225 million was obligated—about one-fourth the cost of an aircraft carrier. And, it took a White House Conference to provide nearly one-half ($100 million in fiscal 1972) this total.[3]

AoA's mission was also seriously undermined by repeated reorganizations—by Democratic and Republican Administrations alike—which had the effect of downgrading it. In 1967 AoA lost its direct line of communication to the Secretary of HEW when it was placed in the welfare-oriented Social and Rehabilitation Service. A further blow was delivered to AoA's sagging prestige when the research and training programs were transferred to the SRS regional offices in 1970. And in 1971 two more of AoA's programs were stripped away: RSVP (the Retired Senior Volunteer Program) and Foster Grandparents were spun off to the new volunteer agency, ACTION.

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[1] For example, when Representative Fogarty was asked why he was willing in 1963 to establish an agency in HEW, rather than support his earlier independent commission proposal, he replied:

"I am just giving in. The Department opposed the independent agency last year and due to their opposition, nothing has been done for a year now, so I am just giving in on that for the time being. I just think the independent commission is the best thing but to get some action I am willing to cooperate with the Department and hope they will support this kind of legislation."

"Hearings on Aging," *Hearings before the House Select Subcommittee on Education on H.R. 7957 and Similar bills;* Sept. 17, 1973; p. 16.

[2] H. Rept. 145 to accompany H.R. 3708; "Older Americans Act of 1965"; 89th Cong., 1st Sess.; Mar. 9, 1965; p. 7.

[3] Older Americans Act Appropriations (fiscal 1966–72):

	Amount
1966	$7,500,000
1967	10,275,000
1968	18,450,000
1969	23,000,000
1970	28,360,000
1971	33,650,000
1972	100,000,000

C. Actions by the Committee on Aging and Other Units

Concern deepened in 1971 about the accelerating deterioration of AoA's role and mission. This interest was heightened by three events:

1. A White House Conference on Aging was to be called in November to formulate a new national policy on aging;
2. The Older Americans Act was scheduled to expire on June 30, 1972; and
3. The Administration's proposed budget for fiscal 1972 called for a $2.5 million cutback in funding for programs under the Older Americans Act.

To provide spade work for future action on the Older Americans Act, Senator Frank Church—as chairman of the Senate Committee on Aging—called together a 21 member advisory council to determine whether AoA should be continued, modified, or replaced.

In its report the advisory council gave this assessment:

> . . . AoA falls far short of being the Federal "focal point in aging" sought by Congress. Instead, its concerns are splintered and scattered; there are limited, if any, policies and few clear-cut goals. Recent reorganizations have not strengthened Federal programs and commitment in aging in any way. Rather, they have fragmented an already flawed and feeble agency still further. This situation has created chaos as well as a lack of direction in Federal and State programs.[4]

The advisory council recommended two major organizational changes to strengthen the Federal Government's commitment in the field of aging. First, it called for the establishment of an independent Office on Aging at the White House level to be directed by an Assistant on Aging to the President. This new agency would have broad powers, including:

—Formulating and administering policy;
—Coordinating and monitoring programs in agencies with a direct concern in matters related to aging; and
—Providing funds for innovative programs to appropriate Federal units.

Additionally, the advisory council proposed to upgrade AoA by placing it under the direction of an Assistant Secretary on Aging.

Hearings on legislative proposals to amend the Older Americans Act were initiated in September 1971 by the Select Education Subcommittee of the House Education and Labor Committee. In the Senate the Subcommittee on Aging of the Labor and Public Welfare Committee began its formal legislative inquiry in March 1972.

D. The White House Conference Recommendations

One of the crucial issues considered by the delegates at the White House Conference on Aging late in 1971 was:

> What should be the Federal Government's commitment in the field of aging, and how should it be structured?

[4] "The Administration on Aging—Or A Successor?"; A Report to the Senate Special Committee on Aging; October 1971; p. 2.

Delegates in the Government and Non-Government Organizations Section supported almost verbatim the recommendations urged earlier in the report of the Committee on Aging's Advisory Council on AoA or a Successor.

The Planning Section also proposed a similar recommendation:

> A separate entity should be created within the Executive Office of the President through legislation and charged with the responsibility for comprehensive planning and advocacy in aging.
>
> This entity should have resources (e.g. authority, funds, staff) adequate to meet this responsibility. The Administration on Aging should be retained within the Department of Health, Education, and Welfare, but it should be raised to the status of an independent agency within the Department, reporting directly to the Secretary.
>
> There should be an interdepartmental committee with representation at the Secretarial level to be chaired by the senior Federal official on aging.[5]

E. Congress and the President Ask Higher Funding

One of the immediate byproducts during and after the White House Conference on Aging was legislative momentum. Nowhere was this more evident than funding for the Older Americans Act.

Early in 1971 the President's budget for fiscal 1972 (July 1, 1971 to June 30, 1972) had called for a $2.5 million cutback in appropriations for the act, from $32 million to $29.5 million. This recommendation brought immediate bipartisan protest from members of the Senate Committee on Aging and others in Congress. Joint hearings[6] were later conducted by the Senate Committee on Aging and the Subcommittee on Aging of the Labor and Public Welfare Committee. An oversight hearing[7] on the Older Americans Act was also conducted by the Select Education Subcommittee of the House Education and Labor Committee. At the April 27 joint hearing[8] in the Senate, Secretary of HEW Elliot Richardson announced that the Administration would raise its budget request from $29.5 to $39.5 million. Welcome as this increase was, it still represented only 38 percent of the $105 million authorized under the Act. As a result Senator Church and the late Senator Prouty pushed for and won further appropriations for the Older Americans Act—raising the funding to $44.75 million.

At the White House Conference President Nixon proposed that the budget for the Older Americans Act be increased to $100 million. And one day after the conference, the Senate overwhelmingly approved Senator Kennedy's amendment to a Supplemental Appropriations bill[9] to boost funding for the Older Americans Act to $100 million, the highest level ever for the act.

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[5] "1971 White House Conference on Aging: A Report to the Delegates from the Conference Sections and Special Concerns Sessions"; S. Doc. 92-53; Dec. 1971; p. 43.

[6] "Evaluation of Administration on Aging and Conduct of White House Conference on Aging"; Joint Hearings before the Special Committee on Aging and the Subcommittee on Aging of the Committee on Labor and Public Welfare, United States Senate; Parts 1-9; Mar. 25, 1971-Aug. 13, 1971.

[7] "Oversight Hearings on Older Americans"; Select Subcommittee on Education of the House Education and Labor Committee; Mar. 10, 1971.

[8] Part 5 of Joint Hearings cited in footnote 6.

[9] Supplemental Appropriations for Fiscal Year 1972; Public Law 92-184 (Approved Dec. 15, 1971).

F. The Nutrition Program for the Elderly Act

The White House Conference on Aging also generated irresistible momentum for the Nutrition Program for the Elderly Act. For more than a year no action had been taken on the legislation, in large part because of the Administration's opposition to the bill. But during the week of the Conference, the Senate approved S. 1163 unanimously (89 to 0).

Nearly 2 months later the Administration reversed its position and agreed to support the bill. In March 1972 the Nutrition Program for the Elderly Act was signed into law (Public Law 92-258), and it became one of the cornerstones in President Nixon's message on aging [10] (for further discussion of the Nutrition Program for the Elderly Act, see Chapter IX).

II. ACTIONS IN 1972

Impetus generated by the White House Conference carried over into 1972 when the Administration offered its proposed changes (S. 3391) to the Older Americans Act. S. 3391—the Older Americans Amendments of 1972—was introduced by Senator Beall on March 21, 1972.

A. Strategy Underlying the Administration's Proposal

A fundamental premise of the Administration's proposal was to improve State and sub-State planning capabilities. Under this approach the Governor of a State would subdivide a State into Planning and Service Areas. Within these PSA's, Area Agencies on Aging would be established or strengthened to serve as a catalyst to develop effective programs on behalf of the elderly. A major purpose of the Area Agency on Aging would be to act as a broker in bringing together the suppliers and recipients of services. However, the Administration did not intend the Area Agencies on Aging to operate these service programs. This point was affirmed in the Senate Labor and Public Welfare Committee report:

> Area agencies are intended, primarily, to coordinate and fund existing service providers rather than to establish themselves as new providers of services to the aging.[11]

A second purpose underlying the Administration's proposal was to develop coordinated services for the elderly by treating problems of the aged more comprehensively and making optimal use of resources. Secretary of HEW Elliot Richardson gave this assessment:

> We propose to help insure that all available Federal resources are planned for and utilized by the State agencies in addressing the needs of older persons. We would accomplish this by:
>
> (*a*) Identifying in advance the resources in each Federal agency available to meet the needs of the elderly,
>
> (*b*) Providing information about these resources through the Administration on Aging—to State aging agencies, and

[10] "Making Recommendations for Action on Behalf of Older Americans"; H. Doc. 92-268; Mar. 23, 1972; pp. 18-19.

[11] S. Rept. 92-1242 to accompany S. 4044; "Comprehensive Older Americans Services Amendments; Sept. 28, 1972; p. 2.

(c) Requiring State agencies to utilize their information in the development of their plans.[12]

Service programs under the Administration's proposal would be designed to implement two major goals: (1) secure maximum independence in a home environment for older persons capable of self-care with appropriate supportive services, and (2) remove barriers to economic and personal independence for older persons who are capable of self-support.

B. Other Administration Actions

In his testimony before the Senate Subcommittee on Aging, Secretary Richardson made two further changes [13] in organizational structure. First, he disclosed that he would expand the role of the Advisory Committee on Older Americans. A principal function of the Advisory Committee would be to advise the Secretary on ways the resources of HEW could be marshalled and coordinated to deal more effectively with the problems of the elderly.

Secondly, he disclosed the establishment of a Technical Advisory Committee on Aging Research. The new Technical Advisory Committee would be located in the Office of the Secretary and would develop a comprehensive plan for social, psychological, health, education, and economic research activities conducted by HEW and affecting the aged.

C. Congressional Response

The Older Americans Comprehensive Services Amendments, as approved by the 92d Congress, incorporated elements of three Senate bills and companion House legislation:

—S. 3076, the Older Americans Act Amendments of 1972 (introduced by Senator Hartke);
—S. 3181, the Action on Aging Act (introduced by Senator Church); and
—S. 3391, the Older Americans Amendments of 1972 (the Administration's proposal, which was introduced by Senator Beall).

The Administration's recommendations for revamping the Title III service programs were accepted in large part in the Older Americans Comprehensive Services Amendments (H.R. 15657).

H.R. 15657 also incorporated several provisions of S. 3076, including:

—Funding for multipurpose senior centers;
—Special impact programs relating to continuing education, preretirement counseling, and transportation services for older Americans; and
—An Information and Resource Center for the Aging.

Additionally, the 1972 Older Americans Act Amendments included modified elements of S. 3181 to upgrade the Administration on Aging and provide it with greater visibility.

D. Manpower Provisions

The Senate bill (S. 4044) incorporated two manpower provisions in its version of the Older Americans Comprehensive Services Amend-

[12] "Older Americans Act Amendments of 1972"; Hearings Before the Subcommittee on Aging of the Committee on Labor and Public Welfare, United States Senate; 92d Cong., 2d Sess.; Mar. 23, 1972; p. 230.
[13] Page 231 of hearings cited in footnote 12.

ments. Title IX of the bill would establish a Senior Service Corps to provide new job opportunities in a wide range of activities for low-income persons 55 or older. Another purpose of Title IX was to convert the Mainstream pilot projects—such as Green Thumb, Senior Aides, and others—into permanent, ongoing national programs.

Title X (the Middle-Aged and Older Workers Training Act) of S. 4044 would establish a midcareer development services program in the Department of Labor to provide training, counseling, and special supportive services for unemployed or underemployed individuals 45 or older. Title X would also authorize strike forces to provide placement and recruitment services in communities where there is large-scale unemployment because of a plant shutdown or other permanent reduction in the work force.

Three important reasons were cited in the Labor and Public Welfare Committee's report[14] for inclusion of the manpower titles:

—Older workers have been historically underrepresented in the Nation's work and training programs. Without specific statutory authorization, the likelihood for improvement would be minimal.

—Unemployment had risen sharply for mature workers since January 1969. In August 1972 there were 1,045,000 persons 45 and older who had lost their jobs, 73 percent greater than in January 1969.

—Middle-aged and older workers have specialized problems which require special attention. Larger proportions, for example, are employed in declining industries—such as agriculture, mining, and railroads. Thousands have had their skills outdistanced by technological advances. And advancing age all too often has seriously limited their occupational mobility.

In response to the Administration's objection to "another categorical manpower program", the Committee included an amendment to authorize the Secretary of Labor to integrate programs under Titles IX and X with any comprehensive manpower legislation subsequently enacted.

The Senate manpower provisions were later adopted with minor modifications by House and Senate Conferees. The Conference bill[15] was then approved by voice vote and without opposition.

E. The President's Message of Disapproval

Despite the strong expression of bipartisan support for the bill, President Nixon pocket-vetoed H.R. 15657 on October 30. Since the veto occurred after the Congress adjourned, there was no opportunity to pass the legislation without the signature of the President.

The President gave three principal reasons for rejecting the bill:

1. The authorized funding was far beyond what could be used effectively and responsibly.
2. The bill would duplicate existing efforts in a number of areas.
3. He opposed the Older American Community Service Employment Act (Title IX) and the Middle-Aged and Older Workers Training Act (Title X).

[14] Pages 21-26 of report cited in footnote 11.
[15] S. Rept. 92-1287 to accompany H.R. 15657; " Older Americans Act; Oct. 11, 1972.

Individual members of the Senate Committee on Aging and several leading organizations in the field of aging—including National Retired Teachers Association-American Association of Retired Persons and the National Council of Senior Citizens—protested the veto.

III. ACTIONS IN 1973

Legislation identical to the vetoed version of the Older Americans Comprehensive Services Amendments of 1972 was reintroduced with strong bipartisan support early in the 93d Congress by Senator Eagleton (S. 50) and Representative Brademas (H.R. 71). S. 50 was cosponsored by 66 Senators, and H.R. 71 by more than 125 Members of the House.

On February 20 the Senate approved S. 50 by a vote of 82 to 9.* The bill, in most respects, was identical to the earlier vetoed proposal. However, the 1973 Senate bill reduced authorized funding for the overall proposal by almost $500 million below the vetoed 1972 legislation

Similar legislation was approved by the House on March 13 by a vote of 329 to 69. Further funding cuts—totaling more than $100 million—were also made by the House.

On April 18, the Senate agreed to the House amendments with further amendments. The Senate amendments reduced the total three-year authorization to $543.6 million (earmarked for Title III Area Planning, Social Services, and State Administration; the Title VI RSVP and Foster Grandparent programs; and the Title IX Older American Community Service Employment Act), for S. 50. However, "such sums as may be necessary" were provided for Title II (National Information and Research Clearing House), Title III Model Projects, Title IV (Research, Training, and Transportation R&D), Title V (Multipurpose Senior Centers), and Title VIII (Education Programs and Senior Opportunities and Services).

Senator Eagleton estimated that the overall three-year authorization for the Older Americans Comprehensive Services Amendments would be approximately $1 billion.

The House also agreed to the Senate amendments on April 18, clearing the measure for action by the White House.

The compromise bill included every substantive program incorporated in the legislation pocket-vetoed by the President in October 1972, with the exception of the Title X Middle-Aged and Older Workers Training Act.

FINDINGS AND RECOMMENDATIONS

The 1973 Older Americans Act Amendments represent landmark legislation in a number of important respects for the Nation's elderly. Authorized funding for the Older Americans Act has been increased to expand earlier successful programs. Innovative ideas and concepts have been incorporated into the legislation, and several new programs have been authorized.

The Congress has spoken forcefully and affirmatively with its overwhelming support for the Older Americans Comprehensive Services Amendments. But this legislation will still require funding if its proposals are to be translated into concrete action for the Nation's elderly.

* This measure was signed into law (P.L. 93-29) on May 3, 1973.

CHAPTER VII

SOCIAL SERVICES FOR THE ELDERLY

No matter what his income, an older person may find that he is unable to maintain independence in his own home without services of one kind or another.

Health-related services, for example, could include referral to the proper agency or facility and arranging for transportation to that care.

Homemaker services assist the person with household maintenance and family management. Meals-on-wheels assure nutritional meals for the homebound individual.

Even when the older person can manage for himself in his own apartment or home, he may stand in need of other kinds of services. Counseling can provide accurate, up-to-the-minute information on Social Security benefits. Legal services can help the elderly avoid pitfalls which can wipe out savings and even fundamental rights.

During 1972 and 1973, social services for older Americans received intensive attention largely because of efforts to reduce mounting costs of service programs authorized under the Social Security Act. Costcutting, however, also rallied supporters of services in an effort to save and even improve them.

I. SOCIAL SECURITY TITLES AND THE 1972 CUTBACKS

Since 1962, services to the elderly have been provided under several titles of the Social Security Act on a 75–25 ratio of Federal to State funds. However, sentiment ran strong in the last session of the 92d Congress to place some type of controls on the spiralling costs created by the open-ended nature of the program. As a result, an amendment was attached to the Revenue Sharing Act which placed a $2.5 billion ceiling on Federal expenditures under the Social Security service titles serving all age groups. The amount allotted to each State under the ceiling was based exclusively on population—without regard to poverty levels or tax effort. No provision for reallocation of a State's unused portion was included. In addition, a restriction was placed upon the State's use of funds. Except for five exempt categories, no greater than 10 percent of a State's allotment could be spent on services for non-welfare recipients. Services for the elderly was not one of the five exempted categories.

Effects of the restrictive legislation were swift and direct. Many senior centers and other providers of service were notified that funding from their State welfare departments was being cut off.

One letter stated:

> Your contract is hereby terminated. . . . It is our understanding that approximately 50 percent of the clients served in your program are recipients of public welfare. We will be

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> glad for you to . . . determine if a new program proposal can be developed so that we can limit our purchase of service to the (welfare) recipient.[1]

Alarmed by numerous reports of cutbacks of social services for senior citizens, the Subcommittee on Federal, State and Community Services of the Senate Special Committee on Aging began an investigation. Findings were published in a report entitled, "The Rise and Threatened Fall of Service Programs for the Elderly," issued on March 15, 1973. The principal cause of cutbacks was found to be a result of the restrictive 90–10 eligibility requirement. However, a difficult situation was made worse with the issuance on February 16 of proposed regulations by HEW for implementation of the new legislation.

II. THE 1973 REGULATIONS

The regulations proposed by the Department of Health, Education, and Welfare, and published in the Federal Register on February 16, if implemented, would seriously curtail the delivery of social services to those persons most vulnerable to loss of independence. There would be no mandated services to the elderly. Not only would a State be able to determine which services, if any, it would provide to the elderly, but in addition, the scope of the defined services would be narrowed. Notably lacking was authorization for funding of legal services.

The proposed regulations would be certain to accelerate the disintegration process, because they would:

- **—Reduce the time of "past" welfare recipient to 3 months, and "potential" welfare recipient to 6 months. Thus, for the elderly, a potential recipient of welfare assistance would have to be a person of at least age 64½, whereas, under current regulations, persons aged 60 can be considered as "potential."**
- **—More closely define a "potential" welfare recipient in terms of income (which could not exceed an amount one-third above the State's level for welfare eligibility) and assets (which could not exceed the State's level for welfare eligibility).**
- **—Eliminate donated private funds and in-kind contributions as sources of matching for the State and local share.**
- **—Create an entangling system of redtape which would obscure the purpose of social service delivery. Redeterminations of eligibility would have to be made as often as quarterly. Present regulations require annual redeterminations.**

Forty-six Senators registered immediate and strong opposition to the proposed social service regulations. In a letter to HEW Secretary Weinberger, the Senators repudiated the withdrawal of private and in-kind contributions as sources of a State's matching. They stated that the existing private-public partnership approach to human problems should be encouraged rather than discouraged.

In addition, strong opposition was expressed by State human resource directors, private service organizations, national organizations on aging, and the elderly themselves.

[1] "The Rise and Threatened Fall of Service Programs for the Elderly," A report of the Subcommittee on Federal, State, and Community Services of the Senate Special Committee on Aging; Report No. 93-94, 93d Cong., 1st Sess., Mar. 1973, p. 11.

In its report,[2] the Subcommittee on Federal, State and Community Services recommended that "organizations on aging, organizations concerned about development of social services for all age groups, and the general public should register opposition to the harsh, regressive, and inappropriate regulations (proposed by HEW)."

III. LEGISLATIVE EFFORTS: 1973

Even before the publication of the proposed HEW regulations, steps at corrective legislation had been taken. On January 29, Senators Scott and Schweiker of Pennsylvania introduced a bill (S. 582) to "allow the States to fund social service programs for nonwelfare poor senior citizens from their total Federal allotment rather than from just the 10 percent reserved for the nonrecipient poor." H.R. 3819, introduced by Representative Heinz of Pennsylvania, on February 6, 1973, would exclude from the application of the 90–10 limitation services to the aged, blind and disabled.

On March 14—after the regulations had been issued—Senator Mondale and 42 cosponsors introduced a bill (S. 1220) which would allow the use of privately contributed funds and in-kind contributions as part of a State's matching share. In addition, the time period for "past" recipient would remain at 2 years. The time period for "potential" recipient would be retained at the present level, which is 5 years. Redeterminations of eligibility would be made annually. Retained also would be a broader definition of social services for the elderly.

In the House of Representatives, on the same date, Congressman Ogden Reid with 82 cosponsors introduced a bill (H.R. 5626) which would remove the 90–10 eligibility requirement from all title funding under the Social Security Act. Accompanying the bill was a Joint Resolution (H.J. Res. 432) which prescribed model regulations governing implementation of the provisions of the Social Security Act relating to the administration of social service programs. The model regulations would retain individual service plans but broaden the goals to include self-care, community-based care and institutional care. Redeterminations of eligibility could not be made less frequently than annually. A potential recipient is defined as one likely to become a recipient of financial assistance within 5 years. No time limit applies to former welfare recipients. Group eligibility in low-income neighborhoods is also included. Unrestricted donated private funds could be considered as State funds in claiming Federal reimbursement. The regulations define the scope of social services, but also provide that additional services may be included in a State plan if accompanied by a written justification and approved by the Secretary.

On March 21, the Democratic Caucus unanimously passed a resolution requesting that the Committee on Ways and Means "promptly report to the floor legislation necessary to enable State and local governments to continue existing programs of social services subject only to the limitations expressly enacted by the 92d Congress."

Secretary Weinberger, by the end of March, was indicating that some changes may be made in the regulations.

[2] Page 33, report cited in footnote 1.

FINDINGS AND RECOMMENDATIONS

The Senate Special Committee on Aging, in its report "The Rise and Threatened Fall of Social Service Programs for the Elderly," [3] (March 1973) made short-range and long-range recommendations dealing not only with the dispute over regulations, but with other issues related to social service needs of older Americans. Those recommendations are reiterated here:

RECOMMENDATIONS—IMMEDIATE

Organizations on aging, organizations concerned about development of social services for *all* age groups, and the general public should register opposition [4] to the harsh, regressive, and inappropriate regulations proposed on February 16 under the heading "Service Programs for Families and Children and for Aged, Blind, or Disabled—Notice of Proposed Rule making". In addition, Congress should consider the desirability of expressing its opposition to the regulations, which go far beyond the intent expressed by Congress when it passed—as an amendment to the Revenue-Sharing Act of 1972—a $2.5 billion ceiling on social services funded under the Social Security Act and new eligibility requirements.

If necessary, individual citizens and private organizations should consider legal action meant to challenge the proposed regulations.

Congress should consider legislation [5] which should exempt from the restrictive 90–10 eligibility requirement services provided to the elderly (defined as persons aged 60 and over). This action should be taken as a first step while Congress considers similar action for other age groups.

The Department of Health, Education, and Welfare should support the instituting of reallocation procedures whereby a State's unused allocation would be redistributed among the other States. Preference for allocation should be given to those States with larger proportions of poor and near poor, and whose supplemental State plans would provide for certain services designed to prevent or reduce institutionalization. A determination of nonutilization of allocation should be made no later than at mid-date of the then current fiscal year. If the implementation of the above suggestion requires legislative action, DHEW should submit an appropriate proposal.

As related to services provided to the elderly, "potential" welfare recipient should be retained as one likely to be reduced to a dependency situation within 5 years. In making such a determination, income, but not assets, would be a controlling factor. The time span for defining a "past" welfare recipient should be retained at 2 years.

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[3] The report also included Individual Views by Ranking Minority Member Hiram Fong and Minority Views by Senators Beall, Hansen, and Percy.

[4] Deadline for sending critical comments to HEW was Mar. 19, 1973. At this writing, however, HEW has not yet announced whether extensive changes will be made.

[5] This could be done by amending Section 1130(a)(2) of the Social Security Act by adding Sub-Section (F) which would read: "services provided to the elderly, defined as persons who have attained the age of 60 years." A bill (S. 582) introduced on Jan. 29, 1973 by Senators Scott and Schweiker of Pennsylvania was intended to "allow the States to fund social service programs for nonwelfare poor senior citizens from their total Federal allotment, rather than from just the 10 percent reserved for the nonrecipient poor." H.R. 3819, introduced by Representative Heinz of Pennsylvania on February 6, 1973, would exclude from the application of the 90–10 limitation services to the aged, blind and disabled.

—Regulation allowing for the inclusion of private funds and in-kind contributions in considering a State's share for Federal reimbursement should also be retained.

RECOMMENDATIONS—LONG-RANGE

Instead of issuing regulations which drastically curtail services, the Department of Health, Education, and Welfare should do a far better job than it has in the past of evaluating the successes, as well as the problems, caused by social services funding under the Social Security Act. HEW should propose a plan for improved reporting procedures at an early date, but these reporting procedures should not serve as simply redtape entanglements meant to discourage use of services by people who need them to reduce the likelihood of dependency, institutionalization, or suffering. A public policy goal should be stated which would affirm the targeting of goals to those persons who are most in need of social services rather than smothering limited resources in excessive administrative costs.

Enactment of the Older Americans Act—expected in the near future—should be followed immediately by an organized survey of sources of services for the elderly of this Nation in order to determine the role that each source can and should play in building a sensible, reliable network of federally-assisted services for older Americans. This survey will be performed in part by the Subcommittee on Federal, State, and Community Services of the Senate Special Committee on Aging, but the Subcommittee should also work with other Congressional units with responsibility in the services area. Full cooperation should be extended by the Executive Branch, as well.

With such information in hand, Congress should then turn once again to recommendations made at the White House Conference and elsewhere in regard to orderly development of a practical, rational system to provide appropriate services to older Americans.

CHAPTER VIII

AGE DISCRIMINATION AND OTHER PROBLEMS OF OLDER WORKERS

Enactment of the Age Discrimination in Employment Act [1] in 1967 offered hope that job opportunities formerly barred to applicants over 40 would now be open to middle-aged and older workers.

But the evidence is all too clear that job bias because of age is still a very real and serious problem today. The most recent Department of Labor report on the age discrimination law [2] reveals that more than one out of every three establishments investigated in fiscal 1972 was found to be in violation of the act. More than 80 percent of these violators were concentrated in three major industries: manufacturing, wholesale and retail trade, and services.

The report also disclosed that employer refusals to hire older workers jumped from 683 in fiscal 1971 to 818 in fiscal 1972. Failure to promote mature workers was involved in 339 instances, nearly 28 percent greater than the previous year. And these figures represent only a fraction of the violations under the law, since many illegal practices simply go unreported.

The inescapable conclusion is that advancing age is still a formidable—and sometimes insuperable obstacle—for employment for middle-aged and older workers.

I. ENFORCING THE AGE DISCRIMINATION LAW

Despite the clearcut need for vigorous enforcement, only 136 court actions, or about 36 per year, had been filed by the Department of Labor through fiscal 1972.

Enforcement is now within the jurisdiction of the Wage and Hour Division of the Employment Standards Administration. However, age bias in employment is just one of many responsibilities of this division. It is also charged with administering the Fair Labor Standards Act, equal pay provisions, the Davis-Bacon Act, and other labor-related statutes.

Consequently, only limited time is devoted to age discrimination activities, although the problem is still severe and may be intensifying. For fiscal 1974 the Administration's budget calls for 1,461 positions to be assigned to the Wage and Hour Division. But only 69—or less than 5 percent—are budgeted for age discrimination purposes. Moreover, this represents a reduction compared with fiscal 1971, when there were 74 budgeted positions.

[1] The Age Discrimination in Employment Act (Public Law 90-202) was enacted to promote the employment of persons of age 40 to 64 on the basis of ability, rather than chronological age. Additionally, the act prohibits discrimination in employment because of age in hiring, job retention, compensation, and other conditions 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.

[2] "Age Discrimination in Employment Act of 1967", a report covering activities under the act during 1972, submitted to Congress in 1973 in accordance with section 13 of the act, U.S. Department of Labor, Employment Standards Administration.

Adequate funding has also been a major stumbling block for effective enforcement of the act. The 1967 law authorizes $3 million for enforcement purposes, but no administration has ever spent one-half that amount. For fiscal 1974, the Administration's budget request is $1,451,000.

A. Gaps in Coverage

Nearly 37 million persons, or about 43 percent of the civilian labor force, are aged 40 to 64. But it is estimated that less than one-half of these workers are now covered by the provisions of the Age Discrimination in Employment Act.

Approximately 10 million individuals employed by State and local governments are outside the scope of the age discrimination law, including more than 4 million estimated to be in the 40 to 64 age classification. Many of these persons are now covered by age discrimination acts in 34 States. However, in many instances these statutes are more loophole than law. And the acts vary markedly with regard to minimum and maximum age limits on coverage, exclusions and exemptions, types of prohibited discriminatory practices, and enforcement sanctions. In addition, employers with fewer than 25 employees are not covered by the provisions of the act.

B. Greyhound Decision: Potential Landmark Case

One of the most encouraging developments for the Age Discrimination Act has been the Greyhound case,[3] which may ultimately set a landmark precedent for enforcement of the law. In that case, Federal District Judge James Parsons held that Greyhound's policy of refusing to consider applicants aged 40 to 64 for initial employment as bus drivers—even those with experience—was not a bona fide occupational qualification reasonably necessary to the normal operation of its business.

In his opinion, Judge Parsons declared:

> . . . I cannot accept the contention that persons over 40 cannot become safe bus drivers. I believe strongly that functional capacity and not chronological age ought be the important factor as to whether or not an individual can do a job safely.[4]

The ruling also noted that Greyhound statistics "actually show that its drivers over age 40 have a better safety record than those under 40." [5]

II. UNEMPLOYMENT AMONG OLDER WORKERS

Unemployment continued at a high level for all age groups throughout 1972, although by year's end the total had dropped to about 4.5 million. For middle-aged and older workers—individuals 45 and above—the employment picture was not nearly as encouraging. Available data strongly support one alarming conclusion: older workers may have been the first to be fired during the economic slowdown, but they are the last to be hired during the recovery.

[3] *Hodgson* v. *Greyhound Lines, Inc.*, USDC ND Ill.—Civil Action No. 69-C-2227 (Decided Feb. 5, 1973).
[4] Page 14 of opinion cited in footnote 3.
[5] Page 10 of opinion cited in footnote 3.

Throughout the year joblessness for persons 45 and above hovered, for the most part, from 900,000 to 1.1 million. In December the total was 900,000, almost 50 percent greater than 4 years ago.

Once unemployed, the older worker runs a substantially greater risk of being without work for long periods of time. In fact, jobless individuals 45 or older can expect to be unemployed 52 percent longer than persons aged 20 to 24; 39 percent longer than individuals in the 25 to 34 age category; and 14 percent longer than persons 35 to 44. Duration of unemployment for persons 45 to 64 averaged almost 16 weeks in December 1972.

Equally alarming is the growing labor force "drop-out" rate for middle-aged and older workers. From January 1972 to January 1973, nearly 800,000 persons aged 45 to 64 withdrew from the work force. In sharp contrast, approximately 2 million jobs opened up for persons under 45 during this same period.

Unemployment figures alone do not provide a complete or accurate barometer of the magnitude of the unemployment problem confronting older workers. One reason is because the jobless figures do not include persons who are not actively seeking work. Today there are 2.6 million men aged 45 to 64 and 11.6 million women in this same age category who are not in the labor force for a variety of reasons, including sheer discouragement. Assuming that just 25 percent of these men and only 5 percent of these women—probably very conservative estimates—wanted and needed employment, this could raise the "real" unemployment for persons 45 and above to 2.1 million.

III. SETBACKS FOR MIDDLE-AGED AND OLDER WORKERS BILL

Yet, our Nation has still failed to develop a clearcut and effective policy to help middle-aged and older workers.

Less than 5 percent of all new enrollees in manpower and training programs are 45 or older. But, mature workers account for 20 percent of the total unemployment (as of January 1973), 27 percent of the long-term joblessness (15 weeks or longer), and 31 percent of the very long-term unemployment (27 weeks or longer). Even in Mainstream[6]—which supposedly is an older worker employment program—individuals 45 or older represent less than a majority (44.1 percent) of all participants.

[6] Mainstream, which is authorized under the Economic Opportunity Act but administered by the Labor Department, is designed to provide public service job opportunities for the chronically unemployed poor who have limited employment prospects because of age or other reasons.

Manpower and training programs: New enrollment (fiscal year 1972)

Program	Total enrollment	45-plus enrollment	Percent	Under 21 enrollment	Percent	55-plus enrollment	Percent
1. Jobs optional	57, 300	4, 360	7. 6	18, 340	32. 0	1, 090	1. 9
2. Job opportunities in the business sector	82, 800	4, 140	5. 0	35, 600	43. 0	(1)	(1)
3. On-the-job-training	24, 800	3, 100	12. 5	8, 090	32. 6	970	3. 9
4. Manpower and Development Training Act (institutional)	150, 600	11, 600	7. 7	57, 080	37. 9	2, 710	1. 8
5. Job Corps	49, 000	----------	----------	49, 000	100. 0	----------	----------
6. Operation Mainstream	31, 400	13, 850	44. 1	1, 190	3. 8	9, 420	30. 0
7. Work incentive program	120, 600	5, 790	4. 8	33, 530	27. 8	720	. 6
8. Concentrated employment program	84, 700	4, 570	5. 4	37, 860	44. 7	1, 270	1. 5
9. Public employment program	226, 100	35, 950	15. 9	33, 010	14. 6	12, 210	5. 4
10. Neighborhood Youth Corps (in-school and summer)	945, 900	----------	----------	945, 900	100. 0	----------	----------
11. Neighborhood Youth Corps (out-of-school)	65, 000	----------	----------	60, 970	93. 8	----------	----------
12. Public service careers:							
Plan A [2]	10, 500	2, 250	21. 4	2, 480	23. 6	1, 270	12. 1
Plan B [3]	11, 200	1, 860	16. 6	2, 020	18. 0	640	5. 7
Plan C [4]	5, 300	400	7. 5	1, 160	21. 9	150	2. 9
Plan D [5]	4, 100	630	15. 3	940	23. 0	(1)	(1)
Plan E [6]	32, 300	3, 550	11. 0	13, 630	42. 2	1, 065	3. 3
13. New Careers in Employment Service	2, 500	410	16. 2	190	7. 5	70	2. 9
Total	1, 904, 100	92, 460	4. 9	1, 300, 900	68. 3	[7] 31, 585	[7] 1. 7

[1] Figures not available.
[2] Entry and upgrading in State and local governments.
[3] Employment and upgrading in grant-in-aid programs.
[4] New careers in human services.
[5] Entry and upgrading in Federal service.
[6] Supplemental training and employment programs.
[7] Total enrollment and percent for 55-plus age category available for programs where information is available.

Major congressional efforts, however, were initiated in 1972 to initiate a comprehensive jobs and training policy for older workers. The Older Americans Comprehensive Services Amendments incorporated two manpower programs:

—The Older American Community Service Employment Act (title IX) which would provide new opportunities in a wide range of public service activities for low-income persons 55 or older; and

—The Middle-Aged and Older Workers Training Act (title X) which would establish a midcareer development services program for unemployed or underemployed individuals aged 45 or older.

Despite the near unanimous approval by the Congress, the President pocket vetoed this legislation after the 92d Congress adjourned.[7]

Similar proposals (S. 50 and H.R. 71) were also reintroduced early in 1973 with strong bipartisan support.[8] The Senate-passed version of the Older Americans Comprehensive Service Amendments incorporated both manpower titles.[9]

The House Education and Labor Committee, however, deleted the Middle-Aged and Older Workers Training provisions.

IV. MANPOWER REVENUE SHARING

A major overhaul of manpower and training programs is proposed in the President's fiscal 1974 budget (submitted to the Congress in January 1973). Particularly significant, the Labor Department budget proposes to lump together several job-training programs—including Manpower Development and Training Act, Operation Mainstream, and others—in a $1.34 billion manpower revenue sharing package. This request, however, is still nearly $340 million below the fiscal 1972 appropriation for manpower.

In addition, the new budget would phase out the Emergency Employment Act, which has already provided public service job opportunities for 226,000 persons. No funds are requested for the public employment program (PEP) for fiscal 1974, although $580 million is expected to be spent during the year as the program is gradually terminated.

Under the administration's special manpower sharing proposal, money would be allocated to State and local governments, which would then determine how the money is to be spent for manpower purposes. For fiscal 1974, the Mainstream older worker projects will continue to be administered nationally and then phased out.

V. "CANCELLED CAREERS"

Over the years the Committee on Aging has been vitally concerned about the trend toward earlier and earlier retirement in private industry and government. In 1972 fresh new perspective was provided on this subject in a report [10] prepared for the Committee by Elizabeth Heidbreder [11] on the impact of the Federal Government's reduction-in-force (RIF) policies on middle-aged Federal employees.

[7] Pocket vetoed on Oct. 30, 1972.
[8] S. 50 was introduced by Senator Eagleton on Jan. 4. The bill is cosponsored by 66 Senators.
[9] S. 50 passed the Senate on Feb. 20, 1973 by a vote of 82 to 9.
[10] "Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees", a report to the Special Committee on Aging, U.S. Senate, May 1972.
[11] Elizabeth M. Heidbreder, economist and research associate with the National Council on the Aging.

The report provided powerful evidence to suggest that the Federal Government, which is oftentimes viewed as a model employer, may actually be a leading offender in applying pressure tactics to coerce older workers to retire at an earlier age. Major findings of the report included:

—The number of involuntary retirements soared since the Office of Management and Budget ordered an across-the-board, 5-percent reduction in agency personnel by June 1972. Figures for fiscal year 1971 revealed that involuntary retirements were 2½ times as great as in 1970 and 6 times the total for 1969. And available data for 1972 are very similar to the monthly averages for 1971.

—A controversial Civil Service rule, allowing agencies to request voluntary resignation of eligible employees before a reduction-in-force takes place, has intensified the pressure for earlier retirement. Under this type of retirement, employees may retire at age 50 with 20 years of service or at any age with 25 years of service.

—Persons involuntarily retired frequently experienced a sharp reduction in income. Annuities for those involuntarily retired typically replaced less than one-half of their prior Government salary.

—A number of Federal training programs are still "off limits" to persons 45 or older, despite the Federal Government's policy of nondiscrimination toward older workers.

At the end of December the Civil Service Commission rescinded its order allowing Federal agencies facing layoffs to "request" the resignation of older employees—in part because of the report on "Cancelled Careers."

VI. DENIAL OF PENSIONS

For many older workers the increase in unemployment during the past 4 years has had a double barreled negative impact: not only have they lost their jobs at a time when their financial responsibilities were the greatest, but thousands have lost their pension coverage as well. Today nearly 30 million workers are covered by over 34,000 private pension plans with assets in excess of $130 billion. However an interim report—"Interim Report of Activities of the Private Welfare and Pension Plan Study"—by the pension study group of the Senate Labor Subcommittee provided disturbing evidence that many workers now covered by private pensions may never collect when they retire.

In 1972 important spade work was undertaken on legislation to make comprehensive reforms in our private pension system. Particularly noteworthy was the Retirement Income Security for Employees Act of 1972 (S. 3598) which was reported out by the Labor and Public Welfare Committee, following an exhaustive 3-year study by the Pension Study Group of the Labor Subcommittee of the Senate Labor and Public Welfare Committee. Five major proposals were made in the bill:

—Employees pension benefits would become 30 percent vested (nonforfeitable) after 8 years of service with one employer. Thereafter, an employee's nonforfeitable benefit would be increased by 10 percent for each additional year, until fully vested after 15 years.

—Minimum funding requirements (over a 30 year period) assure that funds are available for payment of benefits due to employees as obligations arise.
—Provision for insurance to guard against pension plan failures.
—Establishment of a voluntary program for portability of pension credits through a central fund, whereby employees of participating employers may transfer vested credits from one employer to another upon change of employment.
—Establishment of new and stringent fiduciary standards for persons administering pension funds.[12]

The measure was then referred to the Senate Finance Committee, which also claimed jurisdiction over the proposal. On September 25 the Finance Committee re-reported the bill,[13] deleting the provisions for vesting, minimum funding requirements, pension plan insurance, and portability on a voluntary basis. Only the measure for fiduciary standards was retained in the Finance bill. No final action was taken on the Retirement Income Security for Employees Act during the 92d Congress.

Identical legislation (S. 4) to the Labor and Public Welfare Committee version of the Retirement Income Security for Employees Act was reintroduced early (January 3, 1973) during the 93d Congress. On March 5 the bill was ordered reported by the Labor Subcommittee of the Senate Labor and Public Welfare Committee. S. 4 was reported out unanimously by the full committee on March 29, 1973.

FINDINGS AND RECOMMENDATIONS

Despite the enactment of the age discrimination law in 1967, "age-ism" in employment is still widespread. Many myths continue to persist about the work capabilities of older workers. However, many studies have clearly demonstrated that the performance of middle-aged and older persons is at least equal to and oftentimes noticeably better than younger workers.[14]

The committee recommends major changes and educational efforts to overcome "age-ism" in employment, as well as a comprehensive and effective manpower thrust to maximize job opportunities for middle-aged and older workers. Specifically, the committee calls for:

—Amendments to the Age Discrimination in Employment Act to (1) extend coverage to State and local government employees, (2) broaden the application of the law to include employers with 20 or more employees (instead of 25 as under present law) because the act now covers less than 50 percent of all middle-aged and older persons, and (3) increase the authorization from $3 million to $5 million to enforce the act more effectively.

[12] S. Rept. 92-1150 to accompany S. 3598, "Retirement Income Security for Employees Act of 1972", Sept. 18, 1972.
[13] S. Rept. 92-1224 to accompany S. 3598, "Retirement Income Security for Employees Act of 1972", Sept. 25, 1972.
[14] For example, the New York Commissioner of Human Rights conducted a survey of more than 100,000 State employees. One of the major findings was that workers over age 65 performed their jobs "about equal to and sometimes noticeably better than younger workers." ("Job Survey Finds Aged Work Well", by David Andelman, New York Times, Sept. 21, 1972, p. 44.)

—Establishment of "National Employ the Older Worker Week" on a permanent basis to educate the public about the true capabilities of persons in their 40's, 50's, and above.[15]
—Full funding for the Older American Community Service Employment Act.
—Early enactment of the Middle-Aged and Older Workers Training Act.
—Encouragement of job redesign in government and industry to provide greater freedom of choice to older workers who want or need to work.
—Private pension reforms, including provisions for vesting, minimum funding requirements, reinsurance, fiduciary standards, and other essential improvements.

[15] Public Law 93-10 (Approved Mar. 15, 1973) authorized the President to designate the second full week in March of 1973 as "National Employ the Older Worker Week."

CHAPTER IX

NUTRITION, TRANSPORTATION, AND CONSUMER ISSUES

I. NUTRITION PROGRAM FOR THE ELDERLY

"Today hunger is an everyday reality for far too many older Americans. In all probability, malnutrition affects the elderly with a far greater impact than any other age group in our society." [1]

This statement was made by Senator Frank Church, Chairman of the Senate Committee on Aging, in testimony to the Senate Appropriations Committee urging funding for the Nutrition Program for the Elderly.

Senator Edward M. Kennedy, the author of this legislation, also added his support for full funding of the Nutrition Program for the Elderly when he testified before the Senate Labor-HEW Appropriations Subcommittee (hearings not yet in print): "I believe this legislation is the first step toward providing adequate nutrition to isolated elderly Americans."

This request was prompted by an almost year-long stalemate; the originally authorized $100 million for the program for fiscal year 1973 was included in the Labor-HEW Appropriations Bill which was stopped twice by vetoes in 1972. As the Nutrition Program was a "new program" and not active during fiscal year 1972, the appropriations for its implementation were not included in the continuing resolution passed by Congress for Labor and HEW programs in 1973. (A continuing resolution is a measure passed by Congress which allows for temporary funding of programs at their prior year's appropriation or the current year's budget request, whichever is lower.) The statements by Senator Church and Senator Kennedy to the Senate Labor-HEW Appropriations Subcommittee urged that the $100 million needed to inaugurate the program be included in a Supplemental Appropriations Bill being considered by the subcommittee.

In his State of the Union Message concerning Human Resources, (March 1, 1973) the President requested $100 million for Title VII, the Nutrition Program for the Elderly, for fiscal year 1974. Although this figure is below the originally authorized $150 million for the program, the President's request helps to ease the fears that the Administration might try to abandon the food program for the elderly altogether.

A. Authorized, But No Funds

The 1971 White House Conference on Aging recommended that "the Federal Government allocate the major portion of funds for action programs to rehabilitate the malnourished aged and to prevent mal-

[1] News Release from Senator Church—Mar. 22, 1973.

nutrition among those approaching old age." [2] As a result of the White House Conference recommendation and obvious need, the Nutrition Program for the Elderly Act was signed into law on March 22, 1972 and became Title VII of the Older Americans Act. The program had been shown to be severely needed by the 21 pilot programs administered under the auspices of the Administration on Aging (AoA).

These 21 food programs, many of them begun in 1968, clearly demonstrated the demand for nutritional aid for the elderly and firmly established the need for a Federally supported nationwide program.

Congress intended the Title VII program "to provide older Americans, particularly those with low incomes, with low cost, nutritionally sound meals served in strategically located centers, such as schools, churches, community centers, senior citizen centers, and other public or private facilities where they can obtain other social and rehabilitative services. Besides promoting better health among the older segment of the population through improved nutrition, such a program is aimed at reducing the isolation of old age, offering older Americans an opportunity to live their remaining years in dignity." [3]

The States will receive funds in proportion to the number of elderly residing in their State and will in turn award grants to approved project areas within their State.[4] These project areas will establish congregate meal sites throughout the area which must comply with Title VII stipulations of serving at least 100 meals per day, five days a week. Individuals eligible, those 60 and over, will decide themselves what they can pay for the meal as no means test is required. Home-delivered meals [5] may be implemented under Title VII in coordination with a congregate meal site if it is deemed necessary to serve the bed-ridden and homebound.

B. Preparation for Action

The Administration on Aging (AoA) has made extensive preparations to implement the Nutrition Program for the Elderly as soon as funds are authorized.

State plans, operating plans, and guidelines have been developed by many State agencies. Many States have already elected an Advisory Council which according to the regulations must be "functional prior to the approval by the State agency of awards under this part." [6] Project areas have been determined in many States in accordance with the priorities of number of low-income elderly residing there. New meal sites, meal sites used under the earlier pilot projects and Office of Economic Opportunity (OEO) sites which are being "dismantled" are being adapted and developed in conjunction with Title VII requirements that they be conveniently located centers, serve at least 100 hot meals per day, five days a week, and offer supporting social services. Many of the States' local projects are ready to contract with food catering services and commodity food

[2] 1971 White House Conference on Aging, A Report to the Delegates From the Conference Sections and Special Concerns Sessions, S. Doc. 92-53, Dec. 11, 1971.
[3] 45 CFR 909.1(b), Federal Register, Aug. 19, 1972.
[4] A project area is defined by the regulations (45 CFR 909.2(c)) as being the "geographic area for which a single project award is made."
[5] Home-delivered meals or "meals-on-wheels" are programs where meals are brought to the home by volunteers from a congregate kitchen.
[6] 45 CFR 909.20(d), Federal Register, Aug. 19, 1972.

assistance. Most States have progressed as far as possible without funding.

Training of personnel to administer and service the Nutrition Program for the Elderly has begun. Oregon State University was contracted by AoA to develop a short-termed training program on nutrition and related services which would focus on orientation of project directors. Two pilot sessions of this training course were held in January and February of 1973 to test and revise, where needed, the preliminary operation guide and curriculum for the training program. Their training materials will be made available to train nutrition project directors across the country. Several other universities are planning similar training sessions.

C. Need for Action

In his Human Resources Message, the President requested $200 million to fund the programs of the Administration on Aging for fiscal year 1974. Half of this authorized amount is projected to go to the Nutrition Program for the Elderly. Although this $100 million is vastly needed to banish hunger and malnutrition among the Nation's elderly, a much greater amount of funding and action is needed to meet the present situation.

The Nutrition Program for the Elderly as developed in the act and regulations will only provide meals for an estimated 250,000 Americans age 60 and older. However, there are nearly 30 million individuals in this age category, and more than 5 million live in poverty. (Based on 1971 census data.) Many of these persons depend upon the food stamp and surplus commodity programs.

Beginning in January of 1974 the elderly, as well as the blind and disabled, will no longer be eligible for food stamps and commodity assistance, because they will be eligible to receive supplemental security income under H.R. 1 (now P.L. 92–603) if their resources are less than $1,500 for an individual and $2,250 for a couple. This provision would allow for a monthly income from Federal funds of at least $130 for an individual and $195 for a couple for about 6 million aged, blind and disabled persons. The major concern with this provision has been that in many of the States these H.R. 1 benefits would be far below the former assistance payments and food stamp benefits that were offered by the States. In a statement before the Department Operations Subcommittee of the House Committee on Agriculture, Assistant Secretary of Agriculture Clayton Yeutter testified that an estimated 1.5 million aged, blind and disabled will be affected by this provision.[7] Senator Thomas Eagleton and Congressman John Melcher have sponsored legislation in the 93d Congress (S. 255 and H.R. 4825) which would repeal this provision of H.R. 1 and restore to low-income aged, blind and disabled the eligibility to participate in the food stamp and commodity distribution programs.

The need for a national food program for the elderly is evident, as indicated by the great number of aged who suffer from hunger and malnutrition. In a message to Congress, the President stated that "the thought that any older citizen—after a lifetime of service to their

[7] Testimony by Assistant Secretary of Agriculture Clayton Yeutter before the Department Operations Subcommittee of the House Committee on Agriculture—Mar. 13, 1973.

communities and country—may suffer from hunger or malnutrition is intolerable." [8]

FINDINGS AND RECOMMENDATIONS

In complete agreement with this statement, the committee strongly recommends:

Early funding for Title VII, the Nutrition Program for the Elderly.

Full funding of Title VII for fiscal year 1974 and continuation and expansion of the nutrition program thereafter.

Incentives for more home-delivered meal programs under Title VII.

Adequate funding for service and demonstration programs so that personnel may be trained in the field of nutrition and food distribution for the aged.

II. TRANSPORTATION

Transportation remains as one of the more pressing concerns for the elderly. Its importance was summarized in the Final Report of the White House Conference on Aging: [9]

> The elderly, like everyone in society, must depend upon the ability to travel for acquiring the basic necessities of food, clothing and shelter as well as employment and medical care. The ability to travel is also necessary for their participation in spiritual, cultural, recreational and other social activities. To the extent the aged are denied transportation services they are denied full participation in meaningful community life.

Transportation has also been described as "access to opportunities." [10] However, many factors are operating to deny, or at least curtail, the access to opportunities for many older Americans. Transit systems continue to labor under increasing financial difficulties. The immediate result is further reduction of service and increased fares. Additional sources of financing are being explored by Congress, through Federal operating subsidies and options in the use of a State's share of the Highway Trust Fund. Local jurisdictions in increasing numbers are responding by offering reduced fares for the elderly on public transportation.

Additional funding under the Urban Mass Transportation Act to sustain the capital grant program through fiscal year 1977 has been introduced in the current Congress.[11]

A. Difficulties in Measuring Progress

One of the recommendations of the White House Conference on Aging concerned the subject of barrier-free design:

> Transportation systems and services developed or subsidized by public funds shall be designed in an architecturally barrier-free manner in order to provide accessibility for all people.

[8] Message of the President to Congress on Recommendations for Action on Behalf of Older Americans, H. Doc. 92-268, Mar. 23, 1972.
[9] "Toward a National Policy on Aging," Final Report, 1971 White House Conference on Aging, vol. II, p. 65.
[10] "Older Americans and Transportation: A Crisis in Mobility," Report No. 91-1520, Dec. 1970, p. 3.
[11] S. 386, The Emergency Commuter Relief Act, introduced by Senator Harrison Williams, Jan. 16, 1973.

Despite the declared national policy [12] that the elderly and handicapped should have access to mass transportation facilities, uncertainties still exist. The implementation of this policy through the grant and loan provisions of the Urban Mass Transportation Act is discretionary for the Department of Transportation. No specific allotments have been made in the annual DOT budgets for funding of systems designed to meet the special needs of the elderly and handicapped.

There is also no specific legislative requirement that all grants and loans, before approved for funding, assure accessibility on the system to the elderly and handicapped.

Individual projects have been funded. Model prototypes are being developed. But to date, there has been established no systematic implementation of the national policy on accessibility.

Recognizing the need for special emphasis to focus on the transportation problems affecting the elderly, Congress has responded with inclusion of section 412 in the proposed 1973 amendments to the Older Americans Act. That section would authorize an interagency comprehensive study and survey of the transportation problems of older Americans. It would utilize demonstration projects to study a variety of methods and techniques. The objectives of section 412 are parallel to the objectives of a bill, the Older Americans Transportation Services Development Act (S. 1124), introduced by Senator Harrison Williams on March 4, 1972.

B. Experiments and Models

Several innovative transportation projects have either been approved for funding or have begun operations. Upon positive evaluation of the demonstration phase, successful projects will be able to serve as models for other communities with similar transit needs for its aged residents.

The UMTA funded Dial-A-Ride demonstration project in Haddonfield, N.J., which was mentioned in the committee's last annual report, began operations in March 1972. The project is designed to measure public acceptance of door-to-door service and to demonstrate feeder and distribution service for a high speed rail line. *Early evaluation [13] indicates substantial ridership, 17 perceht of whom are over 65.* The system is providing a much needed service to a local medical facility, a significant proportion of whose clientele is elderly.

In Florida, the State DOT has worked in cooperation with the Pinellas County Commission and the Central Pinellas Transit Authority to help seven municipalities in the county start a bus system. Announced [14] were plans to acquire 21 buses to initiate service to the Central Pinellas area and to work towards a cooperative effort for a transfer and reciprocal agreement with the City of St. Petersburg to link one end of the county to the other.

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[12] Section 16, added to the Urban Mass Transportation Act in 1970, stated that: "It is hereby declared to be the national policy that elderly and handicapped persons have the same right as other persons to utilize mass transportation facilities and services; that special efforts shall be made in the planning and design of mass transportation facilities and services so that the availability to elderly and handicapped persons of mass transportation which they can effectively utilize will be assured; and that all Federal programs offering assistance in the field of mass transportation (including the programs under this Act) should contain provisions implementing this policy."

[13] For details, refer to Report by Department of Transportation, item 11,p. 192, this report.

[14] Second Annual Transportation Conference, St. Petersburg Beach, Oct. 9, 10, 1972.

The Pinellas County Commission also announced [15] that it is working in cooperation with the State of Florida, the Tampa Bay Area Regional Planning Council and the Federal Government to attain a mass transit system, which will improve transportation throughout the county.

Denver has been chosen by the U.S. Department of Transportation as the first city in which to demonstrate the concept of people movers, technically termed "Personal Rapid Transit" (PRT). The system is designed to reduce automobile travel in congested metropolitan areas. PRT vehicles in the Denver demonstration are designed to carry six or more people. From central stations computerized control systems direct the vehicles' movements along special guideways, with no crewmen needed on board. PRT has special significance for the elderly because the aged travel primarily within a 3-square mile area of their neighborhoods. The PRT system can be designed for efficient use in such a small area.

In West Virginia an innovative pilot program, aimed both at public transportation development and assistance to lower income ridership, is being considered. The program would distribute transportation stamps to persons over 60 and those in low-income groups in the same manner as food stamps, with the rider paying an amount based on his income. The project would also serve as an incentive to the financially depressed bus lines to devise ways to better serve its patrons, almost all of whom are of lower income. A grant application for $4 million will shortly be resubmitted for Federal funding.

The interrelationship between daily needs of the elderly and transportation was vividly demonstrated in 1972 when a supermarket in Silver Spring, Md., went out of business. Hundreds of residents in a home for the aged just half a block from the supermarket were left without a nearby shopping place. They had to cross two major highways and climb a hill in order to reach the nearest grocery store. In December, the State Commission on Aging awarded a $25,659 grant for the purchase of two minibuses to serve residents of the home for the aged and approximately 100 other elderly residents without nearby shopping areas.[16]

In Ohio—as in West Virginia and Florida—work is underway on on proposals to develop a statewide approach. The Ohio Department of Transportation is working with the State office on aging to develop a plan for a "Senior Citizen and Handicapped Fare Assistance Program."

C. Reduced Fares—How Effective?

Transportation represents the third largest expenditure in the Bureau of Labor Statistics' intermediate budget for a retired couple—after housing and food. Consequently, local communities have in increasing numbers implemented programs of reduced fares for senior citizens, on local transit systems. Although official statistics are not available, it is estimated that over 100 such programs exist. The amount of reduction is generally between 35 and 50 percent of the regular fare. Most programs were originally operative in off-peak hours. However, a trend to extend reduced fares on a 24-hour basis is developing. Chicago recently extended its half-fare program for the elderly from off-peak to a 24-hour basis.

[15] Ibid.
[16] Reported in Washington Star-News, Dec. 26, 1972.

Reduced fares have been financially beneficial to the elderly who, as a group, rely heavily on public transportation. With the implementation of a reduced fare program, ridership increases an average of 15 percent.[17] The effects on transit system revenues and operations has not been definitively evaluated.

Support for reduced fares for the elderly on both surface and air transportation has developed in Congress. Congresswoman Bella Abzug of New York added an amendment to the proposed Housing and Urban Development Act of 1972 which would have required that an applicant for a grant or loan under the provisions of the Urban Mass Transportation Act offer assurances that fares charged to the elderly and handicapped in nonpeak hours would not exceed one-half of the general rate.

Senator Frank Moss introduced on May 10, 1971, a bill (S. 1808) to provide for reduced air fares for persons 65 and older. The bill was attached as an amendment to S. 2280, the anti-hijacking bill. However, the amendment was deleted in Conference Committee.

No legislation pertaining to reduced fares for the elderly was passed by the 92d Congress. Numerous bills providing for reduced fares on airlines, mass transportation facilities and interstate carriers have been introduced in the early days of the 93d Congress.

FINDINGS AND RECOMMENDATIONS

The elderly as a group rely heavily on public transportation facilities. With the passage of time, many elderly come to a point where private means of transportation is no longer available, either because of cost or for physical reasons. Therefore, the only means of participation in community life is through use of a public transportation.

Rather than being curtailed, service on public systems needs to be expanded.

Innovative models, with emphasis on individualized transportation and designed to serve the neighborhood, need to be developed and implementation of these models, once available, needs to be encouraged.

In addition, specific legislative action should be taken to:

- **—Offer reduced fare programs to the elderly on all modes of travel.**
- **—Develop an effective system of monitoring and evaluating progress on the implementation of barrier-free design.**
- **—Secure standards of accessibility on public transportation equipment and facilities.**

III. CONSUMER ISSUES

Inflation remains as a prime concern for the consumer. The cost for basic necessities—such as housing, food, transportation, and health care—continues to climb. All Americans feel the pinch. But the elderly

[17] "The Effect of Reduced Fare Plans for the Elderly on Transit System Routes", by Edward K. Morlock, Walter M. Kulash, and Hugo L. Vandersypen. Transportation Center, Northwestern University, March 1971, p. 6.

as a group on a lower fixed income feel the impact with greater intensity.

Housing represents about 34 percent of their budgets, compared with a national average of 23 percent.

Food consumes 27 percent of the budget of the average retiree. The average family budget pays 17 percent for food.

Rises in the costs of Medicare have occurred, and the Administration proposes more. (See Chapter III).

The recent 20-percent increase in Social Security benefits increased retirement incomes to new levels. But, unrelenting increases in the cost-of-living continue to chip away at the purchasing power of those benefits.

Public transportation, relied upon heavily by the elderly, has seen multiple increases at the fare box. In response, many communities have initiated or expanded programs of reduced or no-cost fares for senior citizens.

Progress on behalf of consumer interests of all age groups has been made. In addition, attention is intensifying on such issues as product safety and product warranty. This progress has special implications for the elderly.

A. Legislative Progress

One of the most important pieces of consumer legislation to be passed by the 92d Congress was the Consumer Product Safety Act. The act, designed to protect consumers from injuries caused by unsafe products, establishes a Consumer Product Safety Commission. A major function of the Commission is to develop safety standards for products. Senator Frank Church, Chairman of the Senate Committee on Aging, has directed a request to the Commission that adequate consideration be given to the elderly as a consumer group.

Additionally, several other significant pieces of consumer legislation have been introduced during the 93d Congress:

—A bill creating the Consumer Protection Agency which would function as an advocate for consumers and consumer interests before departments and agencies of the Federal Government and the courts.

—A national system of no-fault automobile insurance designed to compensate victims more quickly and fairly, to cut down excessive administrative costs like lawyer's fees, and to encourage rehabilitation.

—A bill establishing minimum consumer product warranty disclosures and meaningful remedies for consumers in the event of a breach.

B. Hearing Aids: A Nader Report in Process

Action on behalf of consumers, and especially the elderly, is being taken by the private sector. A Nader affiliate, the Retired Professional Action Group, is studying the consumer aspects of hearing aid use. Publication of a report is expected shortly.

The study began with a review of State laws governing the licensing of hearing aid dealers. It found that many statutes had the effect of

protecting the dealer and offered little, if any, relief for the aggrieved consumer. Notably lacking were adequate, if any, complaint procedures.

The Nader group asserts that people were often encouraged to purchase new hearing aids earlier than necessary.

The cost to the Federal Government for the purchase of hearing aids under different programs was also examined. It became clear that different Government programs were paying different prices for identical items.

C. Action Against Architectural Barriers

Older Americans have a special stake in the success or failure of this Nation in eliminating or substantially reducing physical barriers to accessibility of buildings and transportation systems.

An elderly person—or a younger one who has a temporary or lasting disability—may be denied entry to a building by a flight of stairs or by a door too narrow for a wheelchair. For those still in the work force, barriers might even prevent employment.

Congress enacted an Architectural Barriers Law [18] in 1968 and the Senate Committee on Aging welcomed its passage. Soon, however, it became clear that additional action was necessary. The law lacked enforcement provisions, and its implementation was divided among several jurisdictions.[19]

In 1972, it appeared that the Congress was about to deal with several of the most urgent shortcomings of the statute. One of the provisions of the Vocational and Rehabilitation Act would have created an enforcement arm called the Architectural and Transportation Compliance Board. Acting in consultation with the Compliance Board would have been a National Commission on Transportation and Housing for the Handicapped. The Natioal Commission would have had a representative membership from the private and professional sectors.

The Vocational and Rehabilitation Act, however, was pocket-vetoed by the President on October 27, 1972. In 1973, the Congress again sent a similar bill to the President, but he vetoed that, too, on March 27.

On April 3, the Senate failed to override the veto.

Interest in the barrier issue, however, remains high. Actions have even been taken to make the Federal buildings—new *and* old—on Capitol Hill as accessible as possible.[20]

FINDINGS AND RECOMMENDATIONS

While issues such as inflation and product safety are a concern to all consumers, the elderly consumer is particularly vulnerable in these acreas. With fixed lower income, and lessened mobility the elderly consumer is not in a position of exercising options in the

[18] P.L. 90-480, Approved Aug. 12, 1968.

[19] For additional discussion, see hearings on "A Barrier-Free Environment for the Elderly and Handicapped," Oct. 18, 19, 20, 1971, by the U.S. Senate Special Committee on Aging. See also pp. 68-69, *Developments in Aging: 1970 and January-March 1971*, annual report of the U.S. Senate Special Committee on Aging, May 5, 1972.

[20] Senator Jennings Randolph, chairman of the Subcommittee on Handicapped Workers of the Senate Committee on Labor and Public Welfare, is working with Senator Church, chairman of the Committee on Aging, to improve access to those who work and visit. The Architect of the Capitol has already met with the Senators and committee staff to assure that barriers are removed in the Capitol and in existing or contemplated office buildings.

marketplace. In securing the necessities of life—notably food, housing and medical care—the elderly person usually has two choices: to purchase what is readily available or to go without. That is hardly a "choice" in the acceptable sense of the word.

Therefore, the committee recommends that the following actions be taken:

—Programs related to consumer education should be expanded and designed to include emphasis on the consumer problems of the elderly.
—The Product Safety Commission should direct special attention to the safety of products used extensively by the elderly as a consumer group.
—The Consumer Protection Agency should be established as the advocate of consumers in Federal judicial and administrative proceedings.

CHAPTER X

OTHER AREAS OF CONCERN

I. RESEARCH AND TRAINING

The critical shortage of personnel trained in gerontology continues to be a major obstacle in expanding and providing services for the aged. The need for an adequate number of trained personnel, including knowledgeable generalists as well as specialists, who can put a system into operation effectively and efficiently has long been recognized. Hard scientific facts which would enable social planners, legislators and administrators to make informed judgments on policies and programs pertaining to gerontology must be developed. Although some progress has been made, appropriate research and training programs are far behind the expanding need. As a result, service programs for the elderly are faced with a critical shortage of adequately trained personnel.

And yet, the Administration failed to include any funding for training under the Older Americans Act in its budget request for fiscal year 1974. Research funding was severely decreased.[1] The only programs in this country that are developing knowledge and training personnel to meet the problems of the elderly would be drastically affected by this cut. A discontinuing of Federal support would abandon many training and research centers of gerontology across the Nation.

A. The Need

The need for personnel with knowledge in the field of gerontology was first given recognition by the National Conference on Aging in 1950. It was established and recommended that individuals who planned to administer and offer services to the elderly should possess knowledge of the aging process, be fully aware of the nature and characteristics of older people and their needs, and should promote the specialized skills needed to work with them. In conjunction with this recommendation, several universities created centers and programs in gerontological research and training. Short-term courses were begun by many institutions and the field began to emerge more visibly.

As the demand for social and health services to the elderly increases, the demand for knowledge and service in gerontology grows markedly as well. In 1969 in a report prepared for the Administration on Aging, the Surveys and Research Corporation assessed the need for more training and research when describing the personnel demands for the new programs for the elderly. The report showed that the new programs and services demand personnel trained in a variety of professional fields and for supporting practical and technical tasks.

[1] The budget estimate for research is reduced by $2 million, from a request of $9 million in fiscal year 1973 to approximately $7 million for fiscal year 1974.

These personnel must not only possess the professional and technical skills but also "a knowledge of the progress of aging, and of the special characteristics and needs of older people." [2]

But by 1971 the demand was still prevalent enough for the Gerontological Society to estimate that "the gap between the need for trained personnel and the capacities of present training programs is so great that there is no danger in overtraining for several decades." [3]

B. Institute on Aging

Gerontological programs in research and training are presently scattered among various agencies, including the National Institutes of Health, the National Institute of Mental Health, the Health Services and Mental Health Administration, the National Institute of Child Health and Human Development, and the Administration on Aging. The need and practicality of coordinating all gerontological efforts under one Federal agency has long been recognized. The White House Conference on Aging in 1971 recommended such an institute to "coordinate all federally supported training programs in aging," [4] and the Congress passed a bill (H.R. 14424) in the 92d Congress which would have created a National Institute of Aging. However, this measure was pocket-vetoed by the President in October 1972.

Consequently, Senator Thomas Eagleton reintroduced a bill (S. 775) in the 93d Congress which would provide for the establishment of a National Institute on Aging. The organizing of efforts and information of all research and activities in the field of gerontology into one central coordinating body would help to eliminate duplicated efforts and strengthen the impact of the results. S. 775 was reviewed in a hearing in March of 1973 by the Subcommittee on Aging of the Committee on Labor and Public Welfare. HEW Under Secretary Frank C. Carlucci debated the issue of creating an Institute on Aging with members of the Gerontological Society who strongly support the creation of such an agency. Mr. Carlucci said:

> Aging research requires close coordination and intellectual exchange among many disciplines of science, and its isolation in a separate institute will hamper such exchanges as well as divert needed funds from current research activities to unnecessary overhead costs.[5]

FINDINGS AND RECOMMENDATIONS

The need for more training and research in gerontology is tremendous. More long-term programs toward doctorates and masters in the field, as well as undergraduate programs which would increase the exposure to aging, are greatly in demand. Short-term courses which would aid in increasing the manpower personnel in the field must be expanded. Centers of gerontology and programs at institutions of learning which will further expose the visibility of the aged and their

[2] "The Demand for Personnel and Training in the Field of Aging," a report made by the Surveys and Research Corporation under a contract with the Administration on Aging, p. viii, July 1969.

[3] "Research and Training in Gerontology," a report prepared by the Gerontological Society for the U.S Senate Committee on Aging, p. 33, November 1971.

[4] 1971 White House Conference on Aging, A Report to the Delegates From the Conference Sections and Special Concerns Sessions, Dec. 11, 1971.

[5] Statement by Frank C. Carlucci before the Subcommittee on Aging, Committee on Labor and Public Welfare, U.S. Senate, Mar. 27, 1973.

needs must be continued. With these needs so evident, the committee recommends:

Adequate funding for training and research in gerontological programs for fiscal year 1974.

The creation of more gerontological centers and programs across the Nation which would increase the visibility of the field of aging.

The establishment of a National Institute on Aging which would provide for a centralized agency in which the biological, social, and behavioral aspects of the aging process could be coordinated.

II. DEATH WITH DIGNITY

In August, the Special Committee on Aging began an exploratory inquiry into public issues related to the question of the right to prolong life by extraordinary means when all hope for recovery—or in some cases, even for consciousness or lucidity—had vanished.

The hearings were called "Death with Dignity: An Inquiry Into Related Public Issues."

Committee Chairman Frank Church made several points at the outset of the hearings.

One was that the committee had no preconceived conclusions nor proposals for governmental action. The committee realized that there is a long way to go before anyone could even begin to think about changes in public policy, if indeed such changes should prove to be desirable.

Another point emphasized was:

> We want to take no action that will in any way suggest that we regard any person as expendable, whether that person is one year old or 100 years old.[6]

However, it was recognized that:

> . . . the "Right to Die" issue has its greatest impact upon the elderly population. Chronic illness and terminal illness will increase as our population of older, and very old, Americans continues to increase. Today's unresolved questions related to our subject are likely to intensify unless, finally, they are faced squarely.[7]

In assessing the adequacy of present health care arrangements for the terminally ill patient and his family, the committee inquired into the pressures which place undue emphasis on institutionalization, thereby increasing costs of treatment and anxiety among patients. The wish to die at home was repeatedly expressed by the witnesses—however, the opposite trend is entrenching itself in the present health system. At least 80 percent of the population of this Nation now dies in institutions—facilities such as hospitals and nursing homes. Furthermore, it was found that since the beginning of Medicare, the number of home health programs had actually declined.

[6] "Death With Dignity: An Inquiry Into Related Public Issues," hearing before the U.S. Senate Special Committee on Aging, August, 1972, p. 2.
[7] Ibid, p. 2.

III. THE RURAL ELDERLY

Older Americans in rural areas of the United States received special attention at the White House Conference on Aging, for good reason.[8] It is estimated that more than one out of every four persons 65 and older, or 5.4 million Americans, live on farms or in rural communities.

As can be seen from the following table, large numbers of aging Americans (in this case, age 62 and over) live in rural areas of almost every State.

Ranking of States by number of rural elderly (age 62 and over) [1]

Pennsylvania	398, 043	South Carolina	128, 272
Texas	349, 899	Washington	107, 434
New York	313, 091	New Jersey	100, 814
North Carolina	293, 400	Nebraska	100, 311
Ohio	287, 407	Massachusetts	97, 285
Illinois	256, 612	Maryland	93, 537
Michigan	250, 895	Oregon	85, 785
Missouri	234, 265	Maine	67, 773
California	222, 970	Connecticut	67, 432
Florida	216, 781	South Dakota	58, 382
Indiana	213, 702	Colorado	52, 710
Tennessee	208, 918	North Dakota	52, 095
Kentucky	207, 807	Arizona	42, 175
Wisconsin	207, 318	New Hampshire	41, 574
Virginia	198, 927	Montana	39, 865
Georgia	194, 747	Vermont	37, 873
Iowa	188, 348	Idaho	36, 677
Minnesota	186, 824	New Mexico	29, 279
Alabama	179, 816	Utah	21, 165
Mississippi	163, 322	Delaware	17, 177
Arkansas	152, 320	Wyoming	14, 548
West Virginia	139, 721	Hawaii	13, 115
Oklahoma	137, 715	Rhode Island	12, 403
Louisiana	136, 057	Nevada	8, 497
Kansas	132, 904	Alaska	5, 615

[1] Library of Congress, Ina Nenninger, Economic Analyst.

The Senate Special Committee on Aging, which has already reported on problems affecting the rural elderly,[9] is continuing its inquiries.

A preliminary report [10] received by the committee in February 1973 indicates that the problems discussed by delegates at the White House Conference are still very much in the forefront of concern about the rural elderly.

Described as the most significant problems facing older people living in rural America today are:

—Transportation.
—Delivery of services, especially health care services.
—Housing, especially home repair.[11]
—New restrictions in the provision of services under the Social Security Act (see Chapter VII for additional details).
—Increases in the cost of payments made by Medicare participants.

[8] A "Special Concerns" Session on Rural Older People was held at the conference. For text of recommendations, see pp. 95–97, *1971 White House Conference on Aging: A report to the Delegates*, published Dec. 11, 1971, at the request of the U.S. Senate Committee on Aging.

[9] See pp. 78–90, *A Pre-White House Conference on Aging Summary of Developments and Data*, November 1971; and pp. 85–88, *Developments in Aging, 1971 and January–March 1972, May 15, 1972.*

[10] Prepared by Dr. Blue Carstenson, who was consultant to the committee on rural matters in January–February 1972.

[11] On Jan. 31, Senator Frank Church introduced S. 633, the Older Americans Home Repair Assistance Act. For additional details, see Part Two p. 111 of this report.

—The possibility that revenue-sharing will provide a rationale for the cutting of Federal program funds without providing reasonable alternatives.
—Lack of employment and manpower services.[12]

The committee will look further into the issues raised in the preliminary report and in other committee inquiries.[13]

IV. FUTURE OF OEO PROGRAMS?

What seemed to be new life was breathed into the poverty program in 1972 with passage of the Economic Opportunity Amendments,[14] extending the law for 2 additional years. Additionally, the 1972 act authorized a number of innovative programs with potentially important implications for the Nation's elderly, including:

—An environmental action program offering new employment opportunities for low-income persons on projects designed to combat pollution and to improve the environment; and
—A rural housing development and rehabilitation program.
—Of special significance for the aged poor, the amendments increased the recommended funding authorization for the Senior Opportunities and Services program to $18 million for fiscal 1974.

The act also authorized the Director of OEO to provide financial assistance for projects designed to serve groups of low-income individuals, including the elderly, who are underrepresented in OEO programs.

However, the new funding and programmatic authority for the aged poor was not utilized in 1972. Moreover, in January 1973 the Administration's budget (for fiscal 1974) proposed to dismantle the Office of Economic Opportunity by "spinning off" many of its programs to other existing agencies. Under the Administration's proposal, SOS would be funded on a local option basis beginning in July 1973.

Congressional resistance to this action was expressed immediately by the Senate and House in the Older Americans Comprehensive Services Amendments of 1973, S. 50 (H.R. 71, Comprehensive Older Americans Services Amendments of 1973). Both the Senate and the House included provisions to increase the funding authorizations by $7 million for SOS for fiscal 1973 and 1974. In its report on H.R. 71, the House Education and Labor Committee strongly recommended that SOS be continued as presently constituted and not funded on a local option basis:

> The Committee has included this provision to reaffirm once again the strong intent of Congress to continue SOS as presently constituted, and not be subject to local community decisions to fund these enormously successful programs.[15]

Additionally, efforts were initiated in 1973 by congressional units to prevent the total dismantling of OEO programs, based in part on the contention that the 1972 amendments extended the act through fiscal 1974.

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[12] On Mar. 12, 1973, Senator Hubert Humphrey introduced the Older Workers Conservation Corps Act, S. 1168. For additional details, see Part Two P.115 of this report.
[13] "Special Problems of the Rural Aging," House Report No. 93-103, First Report by the Committee on Government Operations, April 3, 1973.
[14] Public Law 92-464, approved Sept. 19, 1972.
[15] H. Rept. 93-43 to accompany H.R. 71, "Comprehensive Older Americans Services Amendments of 1973", Mar. 2, 1973, p. 26.

FINDINGS AND RECOMMENDATIONS

SOS was first established in 1967 to identify and meet the special needs of low-income persons over age 60. Nearly 700,000 aged poor are now provided a wide range of helpful services under SOS, including homemaker, home health, transportation, legal services, home repair, and many others.

Throughout the Nation SOS has served as a powerful and effective catalyst for affirmative action to provide for the everyday service requirements of the elderly. Without this assistance it is all too likely that the service needs of the aged poor will be either overlooked or largely ignored in many communities.

The committee recommends that SOS be continued as presently constituted and with increased funding authorizations, as spelled out in the Older Americans Comprehensive Services Amendments.

If the Office of Economic Opportunity is completely dismantled, the committee urges that SOS be transferred to the Administration on Aging and funded under authority of the Older Americans Act and the senior opportunities and services legislation—instead of phasing out the Federal support of this enormously successful program.

V. GROWING CONCERN ABOUT LEGAL SERVICES

Legal service programs were first launched in 1965 under authority of the Economic Opportunity Act. Today these programs are operating in 900 neighborhood offices in 300 communities located throughout the Nation, assisting about one million persons.

But during 1972 and in early 1973 concern mounted on two fronts:

1. Would the legal services program for the poor be dismantled?
2. If the program would be continued, what new directions would it take?

A. Actions in 1972

Efforts were initiated in 1971 by Congress and the Administration to establish a Legal Services Corporation. Despite congressional and Executive support for the concept, major differences existed at the outset concerning the President's power to appoint members of the Board of Directors.

The 1971 Economic Opportunity Act Amendments—vetoed by the President in December 1971 primarily because of his opposition to child care provisions—included a provision to establish an independent Legal Services Corporation. But the President also criticized this measure because he would have authority to appoint only six of the 17 directors of the independent corporation.

In an effort to develop OEO legislation more acceptable to the White House, the 1972 Economic Opportunity Act Amendments established a National Legal Services Corporation, but gave the President power to appoint 19 members of the board with the consent of the Senate. However, this provision was still not completely satisfactory from the standpoint of the Administration, and it was dropped to avoid a possible second veto of the entire OEO authorization legislation.

B. Actions in 1973

In the fiscal 1974 budget (submitted in January 1973 to the Congress), President Nixon again called for an independent Legal Services Corporation, but did not provide specific details. Additionally, his budget requested $71.5 million for legal services (approximately the same funding level as for fiscal 1973) to be paid out by HEW (for discussion of proposed dismantlement of OEO, see p. 88) but only if a new Legal Services Corporation were established. As of this date, no Administration proposal has yet been submitted. However, John Erlichman, Chairman of the President's Domestic Council, notified the Subcommittee on Equal Rights of the House Education and Labor Committee on March 7 that the legislation was in the final stages of preparation.

In the House, legislation (H.R. 5109) has been introduced to assure that the legal services program will continue uninterrupted until a corporation is, in fact, established. Moreover, several bills have been introduced—including legislation (amendment No. 5 to S. 706) by Senator Mondale to create an independent Legal Services Corporation. Amendment No. 5 would increase funding for legal services and would permit the President to name 19 members of the Board of Directors.

C. National Senior Citizens Law Center

Another area of growing concern is the threatened closing of the legal service backup centers, including the National Senior Citizens Law Center. NSCLC was initiated in 1972 to increase the availability of legal services for the elderly.

Surveys in the early 1970's indicated that the aged accounted for only about 6 percent of all clients of legal service programs, although they constituted about 20 percent of the total poverty population. Moreover, it is clear that the aged's need—both real and potential—for legal services is great, and may be increasing.

About 21 million persons aged 62 and over receive Social Security benefits; more than 20 million persons 65 and over are covered by Medicare; and an estimated 4.6 million older Americans will be eligible for the Supplemental Security Income program when it becomes operational in 1974. All of these programs involve legal problems of varying degrees for the elderly. Unless legal assistance is available—whether performed by lawyers or paraprofessionals for problems not requiring an attorney—many elderly persons will be forced simply to shift for themselves.

FINDINGS AND RECOMMENDATIONS

The accomplishments of the National Senior Citizens Law Center have been both numerous and outstanding during the center's few short months of existence. The center has provided valuable information and technical assistance to legal services offices regarding special problem areas of the elderly. Equally important, it has served to sensitize legal service attorneys and bar association members about the growing need for increased legal services for the aged poor. But more importantly, the National Senior Citizens Law Center has

served as a forceful and effective advocate on behalf of low-income older Americans.

However, the center is now scheduled to terminate on June 30, unless action is taken to continue its existence.

The Committee on Aging strongly urges that steps be taken to continue funding for the National Senior Citizens Law Center until the proposed Legal Services Corporation becomes operative. The committee further recommends that there be provision for the orderly transfer of the National Senior Citizens Law Center to the Corporation.

VI. MODEL CITIES: WILL SERVICES BE LOST?

Model Cities is one of seven community development programs that the Administration plans to phase out as of June 30, 1973. No new appropriations are requested for this program in fiscal year 1974. The Administration offered the following rationale for phasing out the Model Cities program:

> While serving as a vehicle for demonstrating the value of local decisionmaking, the model cities program does not have a significant enough impact on social and economic problems nationally to justify continued funding as a separate program.[16]

The purpose of Model Cities was to extend financial and technical assistance to participating cities to help them plan, develop, and carry out demonstration programs containing new and imaginative proposals for improving urban living conditions. This program has had its shortcomings, but there are today at least 125 cities with programs providing a variety of services to the elderly. In some cases, the input from Model Cities has been the first real beginning of an active services program outside of traditional welfare sources.

The short range status of Model Cities programs is varied, and the long range forecast is uncertain.

For the next 14 months, or until June 30, 1974, most programs will be able to continue, but at a reduced level. Unspent Model Cities money will be used to fund programs now in effect. It is estimated that the funds will be sufficient to provide localities, on the average, new funds at the rate of 55 percent of the current grant level, from February 1, 1973 to July 1, 1974, with no additional funds thereafter. At the end of fiscal year 1974, Model Cities programs would be eligible for funding under a proposed urban community development revenue sharing program scheduled to begin on July 1, 1974, if approved by Congress.

The overall cutbacks scheduled for the next 14 months are being levied with an uneven hand. While the average cutback is to a level of 55 percent of the current budget, some cities will have only a 20-percent cutback and some cities have been cut out altogether. Regional administrators for HUD have been given the discretion to make quality judgments awarding those cities that have had successful programs. Once the city is informed of its funding level, it may apportion the available funds according to the policies of the local program and the quality of the individual projects.

[16] Appendix, Budget of the United States Government, fiscal year 1974, p. 505.

It is difficult to assess the full impact of these short term policies, because in most cases the hard decisions have not been made. The cities are still in the process of reacting to the new fund limitations.

For the long term, prospects are very uncertain. The urban development revenue sharing bill has yet to be passed by the Congress. Should it pass, the major decisionmaking process would shift to the local level, and current programs will face a battle for their share of the funds.

There are some signs of hope. Model Cities directors in a few cities have been named to new positions of community development directors, and both the National League of Cities and the U.S. Conference of Mayors have supported a "hold harmless" position for ongoing programs under Model Cities.

Despite these efforts, considerable energy will be needed to protect the many programs now serving the elderly under Model Cities. According to a survey taken recently by the National Council on the Aging, at least 20 programs [17] have no plans to continue as Model Cities is phased out, and many other programs face uncertain futures as they search for alternate funding sources.

VII. MINORITY GROUPS

Several of the 1972 legislative victories for older Americans had potentially far-reaching implications for the aged in minority groups:

—A new Federal income supplement program to replace the State administered Old Age Assistance program beginning in 1974.
—Increased Social Security benefits for more than 3 million elderly widows.
—A new special minimum monthly benefit under Social Security for persons with low lifetime earnings and long periods of covered employment.
—Liberalization of the Social Security retirement test.
—Extension of Medicare to disabled Social Security beneficiaries.

Welcome as these advances are, available data strongly suggest that elderly minority groups continue to be among the most disadvantaged in our entire society today.

Poverty by race for persons 65 and over (1970)

	Noninstitutionalized population	Number poor	Percent poor
Negro	1, 530, 151	757, 616	49. 5
American Indian	41, 412	21, 038	50. 8
Japanese	45, 893	9, 158	20. 0
Chinese	24, 906	7, 201	28. 9
Filipino	22, 124	5, 605	25. 3
Hawaiian	3, 310	852	25. 7
Korean	2, 402	1, 058	44. 0
Other	9, 888	3, 169	32. 0
Negro and other races	1, 680, 086	805, 697	48. 0
Spanish origin	398, 346	133, 972	33. 6
White	17, 432, 981	4, 415, 541	25. 3

Source: Unpublished data from Bureau of Census—Based on 5 percent sample of all aged persons in United States.

[17] See Survey of Model Cities Aging Programs, app. 2, p. 257.

Their likelihood of living in poverty is still about twice as great as for the white aged population. Poverty for elderly blacks did decline from 50 percent in 1970 to approximately 39 percent in 1971.[18] But the poverty rate for aged Negroes was still about twice as high as for elderly whites (20 percent). Particularly alarming, more than five out of every eight (64 percent) elderly blacks who live alone or with nonrelatives had incomes below the poverty threshold.

By whatever barometer we would choose to use, members of elderly minority groups run a far greater risk of experiencing deprivation, want and neglect. They are more likely to live in dilapidated housing, suffer from hunger, experience more illnesses, and die earlier. And above all a gap frequently exists between the "availability" and "accessibility" of programs and services meant to serve them.

Powerful new evidence on this point was made in a working paper prepared for the Committee on "Proposals to Eliminate Legal Barriers Affecting Elderly Mexican-Americans." [19] A major recurring theme throughout the report was: elderly Mexican-Americans are among the most economically deprived in our Nation today, but they are also among those least likely to participate in Federal programs.

Several recommendations were urged in the working paper to remove some of the legal impediments hindering participation in Federal programs by aged and aging Mexican-Americans, as well as substantive improvements in present Federal and State programs. Among the major proposals:

—Elimination of the 5-year residency requirement for aliens to participate in part B (Supplementary Medical Insurance) of Medicare.
—Enactment of a requirement that all States must adjust assistance payments to take into account cost-of-living increases.
—Strengthen Federal protection against Medicaid cutbacks by States.
—Assure more adequate assistance payments.

FINDINGS AND RECOMMENDATIONS

Throughout 1973 the Senate Committee on Aging will conduct hearings on "Future Directions in Social Security." Major attention will be devoted to alternative proposals for improving the income position of all older Americans. Another issue to receive close committee scrutiny will be: How can we deal fairly with elderly members of minority groups, so many of whom never live to age 65.

More complete data than now exists, however, will be needed to provide the searching inquiry which the committee hopes to undertake. For this reason the committee urges that appropriate Federal agencies—including the Bureau of the Census, Bureau of Indian

[18] *Current Population Reports*, "Consumer Income: Characteristics of the Low-Income Population 1971," Series P–60, No. 86, December 1972, U.S. Department of Commerce, Social and Economic Statistics Administration, Bureau of Census.

[19] "Proposals to Eliminate Legal Barriers Affecting Elderly Mexican-Americans", Special Committee on Aging, U.S. Senate, May 1972. The working paper was prepared by Cruz Reynoso (Director, California Rural Legal Assistance) and Peter D. Coppelman (project director, California Rural Legal Assistance, Senior Citizens' Project, San Francisco, Calif.).

Affairs, Social Security Administration, and Bureau of Labor Statistics—undertake studies and surveys at the earliest possible date to provide more complete and current information about elderly minority groups.

Further, the committee urges that appropriate congressional units conduct prompt hearings on the legislative recommendations in the working paper on "Proposals To Eliminate Legal Barriers Affecting Elderly Mexican-Americans."

PART TWO

SUMMARY OF LEGISLATIVE ACTIONS TAKEN FROM JANUARY 1972 TO APRIL 1, 1973

Major congressional actions on behalf of older Americans have been described, in some detail, in Part One of this report.

This section gives details on legislative history of the bills and provides information on proposals not mentioned or only briefly referred to in Part One.

I. PROPOSALS RELATING TO RETIREMENT INCOME [1]

20-Percent Social Security Increase (Church Amendment)

A. Legislative History

Senator Church's proposal for a 20-percent Social Security increase was adopted (by a vote of 82 to 4) as an amendment to the debt ceiling legislation (H.R. 15390) on June 30, 1972. A few hours later the House agreed to this measure by a vote of 302 to 35. On July 1, H.R. 15390—along with the Church amendment—was signed into law.

B. Major Provisions

The Church amendment provided for a 20-percent across-the-board increase in Social Security benefits (for checks mailed in October 1972) for 28 million persons. Additionally, the measure will provide for automatic cost-of-living adjustments (beginning in 1975) to help make Social Security inflation proof for the elderly.

C. Status as of April 1, 1973

The Church amendment became law (P.L. 92-336) on July 1, 1972.

20-Percent Increase in Railroad Retirement Annuities (H.R. 15927)

A. Legislative History

H.R. 15927 was approved by the House on August 9, 1972, and by the Senate on September 29. On October 4 the President vetoed the bill. However, the Congress decisively and swiftly overrode the veto on October 4 by a vote of 353 to 29 in the House and 76 to 5 in the Senate.

B. Major Provisions

H.R. 15927 provided a temporary (scheduled to expire on June 30, 1973) 20-percent increase in Railroad Retirement annuities for more than 700,000 railroad workers and their dependents. The act also directed representatives of management and labor to report to the Congress on their mutual recommendations to insure the solvency of the Railroad Retirement account and to make the increase permanent.

[1] For additional information on major bills discussed in this section, see Chapter II, Part One, p. 12.

C. Status as of April 1, 1973

H.R. 15927 became Public Law 92–460 without the signature of the President on October 4, 1972.

1972 Social Security Amendments (H.R. 1)

A. Legislative History

H.R. 1 was passed by the House of Representatives on June 22, 1971, and by the Senate on October 5, 1972. Differences in the House and Senate versions were then resolved in conference committee. The bill was approved on October 17 by the House and Senate. The President signed the bill into law on October 30, 1972.

B. Major Provisions

The cash benefits provisions in H.R. 1 are discussed in detail in Chapter II, Part One.

C. Status as of April 1, 1973

Most of the provisions in H.R. 1 (P.L. 92–603) became effective in January 1973. However, Medicare coverage for the disabled will become effective in July 1973, and the new Supplemental Security Income program will become operative in January 1974.

Proposed Increases in Veterans' Pensions (S. 4006)

A. Legislative History

S. 4006 was introduced by Senator Hartke on September 19, 1972. The bill was passed by the Senate on October 11, 1972. However, there was not sufficient time for the House to act on the bill before adjournment of the 92d Congress.

B. Major Provisions

S. 4006 proposed (a) a $400 increase in the annual income limitations for veterans and their survivors and (b) a boost in pension rates averaging 8 percent.

C. Status as of April 1, 1973

Identical legislation (S. 275) was reintroduced by Senator Hartke on January 9, 1973.

II. PROPOSALS RELATING TO HEALTH CARE

1972 Social Security Amendments (H.R. 1)

A. Legislative History

(See preceding discussion of H.R. 1 above.)

B. Major Provisions

(Changes in Medicare and Medicaid are discussed in detail in Chapter III, Part One) [2]

C. Status as of April 1, 1973

(See preceding discussion of H.R. 1 above.)

[2] See pp. 25–26.

Health Maintenance Organization and Resource Development Act (S. 3327)

A. Legislative History

Senator Kennedy introduced S. 3327 on March 13, 1972. The Senate approved this measure by a vote of 60 to 14 on September 20. S. 3327 was then referred to the House Interstate and Foreign Commerce Committee on September 25. However, no final action was taken on this legislation by the House before the Congress adjourned.

B. Major Provisions

S. 3327 provided support for health maintenance organizations, supplemental health maintenance organizations, health service organizations, and area health education and service centers. Additionally, it provides for the establishment of an independent Commission on Quality Health Care Assurance.

C. Status as of April 1, 1973

Senator Edward Kennedy reintroduced similar HMO legislation (S. 14) on January 4, 1973.

Public Health Service Act Extension of 1973 (S. 1136)

A. Legislative History

On September 20, 1972, the Senate passed S. 3716, which provided for one-year extensions of Public Health Service Act programs which were due to expire June 30, 1973. The bill was intended to provide Congress with sufficient time to consider whether each of the affected programs should be extended, modified, or ended. The House, however, failed to act on the extension bill before adjournment of the 92d Congress.

On March 8, 1973, S. 1136, the Public Health Service Act Extension of 1973, was introduced in the Senate. It was passed by the Senate on March 27, 1973, by a vote of 72 to 19. Its purpose is the same as that of the 1972 extension proposal. A similar measure, H.R. 5608, was introduced in the House on March 14, 1973.

B. Major Provisions

S. 1136 would extend for one year, through fiscal year 1974, at 1973 authorization levels, the following programs: health services research and development; health statistics; public health training; migrant health; comprehensive health planning; Hill-Burton hospital construction and modernization; regional medical programs; allied health training; medical libraries; and community mental health centers.

H.R. 5608 would extend the same programs as does the Senate bill, with the following additions: public health training; population research and family planning; and the Development Disabilities Construction Act.

C. Status as of April 1, 1973

Hearings on H.R. 5608 were concluded on March 29, 1973, by the Subcommittee on Public Health and Environment of the House Interstate and Foreign Commerce Committee.

Health Security Act (S. 3)

A. Legislative History

On January 25, 1971, Senator Edward M. Kennedy introduced the Health Security Act (S. 3). A companion measure, H.R. 22, was introduced on January 22, 1971, by Representative Martha W. Griffiths. S. 3 was referred to the Senate Committee on Finance, where hearings were held but no further action was taken. H.R. 22 was referred to the House Ways and Means Committee, where hearings were completed but no further action was taken.

S. 3 was reintroduced in the 93d Congress on January 4, 1973. The companion measure, H.R. 22, was reintroduced on January 3, 1973.

B. Major Provisions

S. 3 and H.R. 22, as originally introduced, contained these major provisions affecting the elderly:

1. Medicare would be replaced by a health insurance program and Medicaid would become a supplementary program. Beginning in mid-1973, there would be provision for comprehensive health insurance coverage, including preventive and disease detection services; care and treatment of illness; and medical rehabilitation.

2. There would be no cutoff points; no coinsurance (requiring out-of-pocket payments as under Medicare); no deductibles (calling for additional payments by patients as Medicare does); and no waiting period. Coverage under the program would be automatic. There would be no "means test" (as under Medicaid).

3. Virtually all health services would be covered in full except there would be certain limitations for nursing home care; dental care; psychiatric care; and prescription drugs.

S. 3 and H.R. 22, as reintroduced in the 93d Congress, contain these major changes affecting the elderly:

1. *Dental benefits.* The Health Security Board is authorized to extend the coverage for dental services (limited to children up to age 15 at the start) faster than the timetable specified in the legislation if adequate manpower is available. In addition, the Board is required, within seven years of the effective date of the legislation, to publish a timetable for phasing in the entire adult population.

2. *Health Maintenance Organizations.* The name "comprehensive health service organization" is changed to "health maintenance organization." HMO's will now be required to furnish or arrange for all covered services except mental and dental services.

3. *Professional Foundations.* Medical foundations are given the same expanded drug benefit previously available only in HMO's. That is, a full range of prescription drugs is now covered for all patients served through HMO's or foundations. The foundations are required to provide the same range of services as an HMO.

4. *Maintenance and Long-Term Care.* A new section gives the Health Security Board authority to make grants for pilot projects to test the feasibility of home maintenance care for chronically ill or disabled people. If experience under these projects proves that home maintenance services reduce the need for institutional care and can be administered in such a way as to control inappro-

priate or unnecessary utilization, the Health Security Board is authorized to recommend expansion of these services to the entire population.

C. Status as of April 1, 1973

S. 3 has been referred to the Senate Committee on Finance. H.R. 22 has been referred to the House Ways and Means Committee. Hearings are expected on these measures and other national health insurance proposals, but no dates have been set as of this time.

III. PROPOSALS RELATING TO LONG-TERM CARE [3]

1972 Social Security Amendments (H.R. 1)

A. Legislative History

(See discussion of H.R. 1 on p. 96.)

B. Major Provisions

(Medicare and Medicaid changes affecting long-term care are discussed in detail in Chapter IV, Part One.)

C. Status as of April 1, 1973

(See discussion of H.R. 1 on p. 96.)

IV. PROPOSALS RELATING TO HOUSING [4]

Housing and Urban Development Act of 1972 (S. 3248)

A. Legislative History

The Housing and Urban Development Act of 1972 (S. 3248), which included a number of important provisions for older Americans, passed the Senate on March 2, 1972, by a vote of 80 to 1.

B. Major Provisions

Major provisions of S. 3248 affecting the elderly included the following:

1. The authorization level of the section 202 program for the elderly would be increased to $750 million, an increase of $100 million.

2. A new position of Assistant Secretary of Housing for the Elderly would be established at the Department of Housing and Urban Development to administer all HUD programs providing assistance to the elderly.

3. In the Multifamily Housing Assistance section (502), not less than 15 percent nor more than 25 percent of the total funds appropriated would be available for projects planned in whole or in part for the elderly.

4. The Secretary of Housing and Urban Development would be authorized to make additional assistance payments or rent supplement payments for up to 60 percent of the units in any multifamily housing project (section 502) in which all or substantially all of the units are occupied by elderly families.

[3] For additional information on major bills discussed in this section, see Chapter IV, Part One, p. 31.
[4] For additional information on major bills discussed in this section, see Chapter V, Part One, p. 42.

C. Status as of April 1, 1973

The House companion bill (H.R. 16704) was reported out of the Banking and Currency Committee on September 21, 1972. However, the House Rules Committee did not act on this legislation because it believed that there was too little time left in the session to consider a bill so large with so many controversial sections.

Continuing Resolution (H.J. Res. 1301)

A. Legislative History

H.J. Res. 1301 passed the House on October 2, 1972, and passed the Senate with an amendment on October 6, 1972.

B. Major Provisions

As finally approved, H.J. Res. 1301 extended the authority for all FHA insurance programs from October 1, 1972, to June 30, 1973. It also authorized $150 million more for public housing and $250 million more for urban renewal.

C. Status as of April 1, 1973

H.J. Res. 1301 was approved on October 18, 1972, and became Public Law 92–503.

V. PROPOSALS RELATING TO OLDER AMERICANS ACT [5]

Older Americans Comprehensive Services Amendments (H.R. 15657—S. 4044)

A. Legislative History

H.R. 15657 (the Comprehensive Older Americans Services Amendments) passed the House by a vote of 351 to 3 on July 17, 1972. Similar legislation (S. 4044) was unanimously approved (89 to 0) in the Senate on October 3. In conference committee the short title of the bill was changed to the Older Americans Comprehensive Services Amendments. On October 30 the President pocket-vetoed H.R. 15657.

B. Major Provisions

Major changes and innovations were incorporated in the Older Americans Comprehensive Services Amendments of 1972. Among the key provisions:

Federal Council on Aging.—A 15-member Federal Council on Aging would replace the Advisory Committee on Older Americans. The new Council would advise and assist the President on matters relating to the special needs of older Americans.

It would also act as a spokesman on behalf of the elderly in making recommendations to the President and Congress concerning Federal policies in the field of aging. And, the Council would undertake a study of (a) the interrelationship of programs for the elderly and (b) the combined impact of all taxes affecting the aged.

Strengthening of Administration on Aging.—Three fundamental changes were incorporated in H.R. 15657 to strengthen AoA: (1) AoA would be transferred out of the Social and Rehabilitation Service to the Office of the Secretary of HEW; (2) the Commis-

[5] For additional information on major bills discussed in this section, see Chapter VI, Part One, p. 53.

sioner would be directly responsible to the Secretary; and (3) the Commissioner would not be able to delegate any of his functions to any officer who is not responsible to him unless he submits a delegation plan to the Congress.

Model projects.—A Model Projects program would be established to concentrate on special problems of the elderly, including housing, transportation, continuing education, preretirement counseling, and social services for handicapped elderly Americans.

Title III grants for State and area programs.—The existing Title III Community Grants program would be replaced by new State and Area programs to encourage the development of comprehensive and coordinated social service systems through the establishment of planning and service areas.

Special study and demonstration projects on the transportation problems of older Americans.—A special study would be authorized to focus on several possible solutions for the transportation problems of the elderly, including (a) the use of community transportation facilities, school buses, and excess Department of Defense vehicles and (b) the need for revised and improved procedures for obtaining motor vehicle insurance by older Americans. Additionally, the Commissioner would be directed to conduct research and demonstration projects to improve transportation services for the elderly by establishing special transportation subsystems, portal to portal services, and making payments directly to the elderly to enable them to obtain transportation services.

Multidisciplinary centers of gerontology.—Federal funding would also be authorized for new multidisciplinary centers of gerontology to conduct basic and applied research on (a) work, leisure, and education of older Americans; (b) living arrangements; (c) the economics of aging; and (d) other related areas.

Multipurpose senior centers.—Federal funding would be authorized for leasing, altering, renovating, or constructing facilities to be used for multipurpose senior centers. Federal funding would also be authorized to cover the costs of professional and technical personnel.

Foster grandparents.—The concept of the foster grandparent program would be expanded to include supportive services to children and adults in community settings, as well as services for institutionalized children.

Training.—Authorized funding for training would be increased to $15 million in fiscal 1973; $20 million in fiscal 1974; and $25 million in fiscal 1975.

C. Status as of April 1, 1973

Senator Eagleton reintroduced the Older Americans Comprehensive Services Amendments (S. 50) on January 4, 1973. Companion legislation (H.R. 71) was introduced by Representative Brademas on January 3. S. 50 was approved by the Senate on February 20 by a vote of 82 to 9. Similar legislation—although at a reduced funding level—was passed (329 to 69) in the House on March 13.

VI. PROPOSALS RELATING TO SOCIAL SERVICES [6]

Socal Services to the Aged (S. 582)

A. Legislative History

S. 582 was introduced by Senators Scott and Schweiker on January 29, 1973. The bill has been referred to the Committee on Finance.

B. Major Provisions

The bill would exempt social services to the aged under the Social Security Act from the requirement that not more than 10 percent of a State's funding allotment could be directed toward non-welfare recipients.

C. Status as of April 1, 1973

S. 582 is pending in the Finance Committee.

Social Services to the Aged, Blind and Disabled (H.R. 3819)

A. Legislative History

H.R. 3819 was introduced by Representative Heinz on February 6, 1973, and was referred to the Committee on Ways and Means.

B. Major Provisions

H.R. 3819 would exempt social services to the aged, blind and disabled under the Social Security Act from the requirement that not more than 10 percent of a State's funding allotment could be directed toward non-welfare recipients.

C. Status as of April 1, 1973

The bill is pending in the Ways and Means Committee.

Limitation on Social Services Regulations (S. 1220)

A. Legislative History

S. 1220 was introduced by Senator Mondale and 42 cosponsors on March 16, 1973.

B. Major Provisions

The bill would limit the authority of the Secretary of Health, Education, and Welfare to impose, by regulations, additional restrictions on the use of Federal funds under the Social Security Act. Five areas under existing regulations would be preserved. Four areas are of interest to the elderly:

—The use of privately contributed funds and in-kind contributions as part of a State's share for Federal reimbursement.
—The authority of a State to define classes of individuals eligible to receive social services.
—The authority of a State to include as social services in its State plan comprehensive service programs for the elderly.
—Reasonable reporting requirements.

C. Status as of April 1, 1973

S. 1220 is pending in the Senate Finance Committee.

[6] For additional information on major bills discussed in this section, see Chapter VII, Part One, p. 61.

Social Services (H.R. 5626)

A. Legislative History

H.R. 5626 was introduced on March 14 by Representative Reid and 82 cosponsors.

B. Major Provisions

The bill would exempt all social services funded under the Social Security Act from the requirement that no greater than 10 percent of a State's allotment could be directed toward nonwelfare recipients.

C. Status as of April 1, 1973

This bill is pending in the House Ways and Means Committee.

Model Regulations for Social Services (H.J. Res. 432)

A. Legislative History

H.J. Res. 432 was introduced by Representative Reid and 82 cosponsors on March 14, 1973.

B. Major Provisions

The joint resolution prescribed model regulations governing implementation of the provisions of the Social Security Act relating to the administration of social service programs. Certain areas are of interest to social service programs for the elderly.

—The model regulations would prescribe individual service plans but goals would be broad and would include self-care, community-based care and institutional care.
—Redeterminations of eligibility could not be made more often than annually.
—"Potential" welfare recipient would be defined as one likely to become a recipient of financial assistance within 5 years.
—No time limit would apply to former welfare recipients.
—Group eligibility in low-income neighborhoods would be included.
—Unrestricted donated private funds could be considered as State funds in claiming Federal reimbursement.
—Although the scope of social services would be defined, additional services could be included in a State plan if accompanied by a written justification and approved by the Secretary of HEW.

C. Status as of April 1, 1973

H.J. Res. 432 has been referred to the House Ways and Means Committee, where it is pending.

VII. PROPOSALS RELATING TO AGE DISCRIMINATION AND OTHER PROBLEMS OF OLDER WORKERS [7]

Age Discrimination in Employment Act Amendments

A. Legislative History

An amendment sponsored by Senator Bentsen was incorporated in S. 1861—the Fair Labor Standards Amendments—when the Senate Labor and Public Welfare Committee reported this bill on June 8, 1972. S. 1861, including the Bentsen amendment, was approved by the Senate on July 20, 1972. However, the House failed to agree to

[7] For additional information on major bills discussed in this section, see Chapter VIII, Part One, p. 66.

go to conference committee with the Senate to reconcile differences in the two versions of the minimum wage legislation (the House bill did not include amendments to the Age Discrimination in Employment Act). Consequently, the Congress adjourned without enacting the minimum wage and age discrimination amendments.

B. Major Provisions

The Bentsen amendment would have extended the application of the Age Discrimination in Employment Act to employees of State and local governments. Additionally, the amendment would have established age discrimination employment standards for Federal employees, with enforcement responsibilities assigned to the Civil Service Commission.

C. Status as of April 1, 1973

Similar legislation (S. 635) was reintroduced by Senator Bentsen early (January 31, 1973) in the 93d Congress.

Retirement Income Security for Employees Act (S. 3598)

A. Legislative History

S. 3598—the Retirement Income Security for Employees Act—was reported out by the Senate Labor and Public Welfare Committee on September 15, 1972. The bill was re-reported by the Senate Finance Committee on September 25, but without the provisions for vesting, minimum funding requirements, reinsurance, and portability of pension credits. No final action was taken in the Senate.

B. Major Provisions

Major provisions in the Labor and Public Welfare Committee bill included:

—Vesting requirements to entitle employees to 30 percent of accrued pension credits after 8 years of service, and an additional 10 percent for each year thereafter until fully vested after 15 years.
—Funding requirements to assure that all pension liabilities will be funded after 30 years.
—A Federally-administered mandatory insurance program to protect plan participants against loss of benefits because of pension plan failures.
—A voluntary program for portability of pension credits through a central fund administered by the Department of Labor.
—New rules of conduct for pension fund trustees and fiduciaries.

C. Status as of April 1, 1973

The Retirement Income Security for Employees Act was reintroduced (January 4, 1973) as S. 4 during the 93d Congress by Senators Williams and Javits. S. 4 was ordered reported by the Labor Subcommittee of the Senate Labor and Public Welfare Committee on March 5, 1973. The bill was then reported out unanimously by the full committee on March 29, 1973.

Older American Community Service Employment Act (Title IX of the Older Americans Comprehensive Services Amendments, H.R. 15657—S. 4044)

A. Legislative History

Senator Kennedy introduced S. 555 (the Older American Community Service Employment Act) on February 2, 1971. Hearings were held on S. 555 and other employment measures by the Subcommittee on Aging of the Senate Labor and Public Welfare Committee in July 1971. S. 555 was ordered reported by the full committee on June 21, 1972. The Senate unanimously approved (77 to 0) this legislation on September 21, 1972. Because it was not possible for the House to act on this proposal before adjournment, S. 555 was added as Title IX to S. 4044, the Comprehensive Older Americans Services Amendments. Title IX was retained in the conference report on the bill (H.R. 15657—S. 4044). However, the President later pocket vetoed (on October 30, 1972) H.R. 15657.

B. Major Provisions

S. 555 would create new job opportunities in a wide range of community service activities for low-income persons aged 55 and above. A 2-year funding authorization of $250 million was provided to carry out the purposes of the act.

C. Status as of April 1, 1973

The Older American Community Service Employment Act was included as Title IX of S. 50, the Older Americans Comprehensive Services Amendments, which was approved by the Senate on February 20, 1973. The House-passed (March 13, 1973) version also retained Title IX but reduced funding for the older worker employment program by $100 million.*

Middle-Aged and Older Workers Training Act (Title X of the Older Americans Comprehensive Services Amendments, H.R. 15657—S. 4044)

A. Legislative History

Senator Randolph introduced S. 1307 (the Middle-Aged and Older Workers Employment Act) on March 19, 1971. Hearings were held on this legislation by the Subcommittee on Aging of the Senate Labor and Public Welfare Committee in July 1971. The bill was ordered reported by the Labor and Public Welfare Committee on June 21, 1972. However, to expendite its consideration, this measure was added in modified form (the short title of the legislation was changed to the Middle-Aged and Older Workers Training Act) as Title X of S. 4044, the Comprehensive Older Americans Services Amendments. This title was retained in amended form in the conference report on this legislation (H.R. 15657—S. 4044). The conference bill was pocket vetoed by the President on October 30, 1972.

B. Major Provisions

The Middle-Aged and Older Workers Training Act would establish a comprehensive Midcareer Development Services program to provide training, counseling, and special supportive services for unemployed or underemployed persons aged 45 or older. Moreover, it would

* On May 3, 1973, S. 50 (The Older Americans Comprehensive Services Amendments) was signed into law.

authorize "strike forces" to provide placement and recruitment services in communities where there is large scale unemployment because of a plant shutdown or other permanent reduction in the work force.

C. Status as of April 1, 1973

The Middle-Aged and Older Workers Training Act was reintroduced as Title X of the Older Americans Comprehensive Services Amendments (S. 50) on January 4, 1973. S. 50 passed the Senate on February 20 by a vote of 82 to 9. However, Title X was deleted from the House version of this legislation (H.R. 71). H.R. 71 passed the House on March 13, 1973.

VIII. PROPOSALS RELATING TO NUTRITION [8]

Nutrition Program for the Elderly (S. 1163)

A. Legislative History

S. 1163 was approved unanimously (89 to 0) by the Senate on November 30, 1971. The House passed almost identical legislation on February 7, 1972, and the Senate agreed to the House amendment on March 7, 1972. President Nixon signed the bill into law (P.L. 92–258) on March 22, 1972.

B. Major Provisions

S. 1163 authorized a national hot meals program for persons 60 and over in conveniently located centers, such as senior citizen centers, schools, and other nonprofit settings. Funding in the amount of $250 million—$100 million for fiscal 1973 and $150 million for fiscal 1974—was authorized to carry out the purposes of the Act.

C. Status as of April 1, 1973

No funding has been provided for this law because the President has vetoed two Labor-HEW appropriations bills in 1972. However, efforts were initiated in 1973 by Senators Kennedy and Church to win funding in a Supplemental Appropriations bill for the Nutrition Program for the Elderly.

IX. PROPOSALS RELATING TO TRANSPORTATION [9]

The Emergency Commuter Relief Act (S. 386)

A. Legislative History

S. 386 was introduced by Senator Williams on January 16, 1973, and was referred to the Committee on Banking, Housing and Urban Affairs. Hearings were held in February. Almost identical provisions of the bill were passed by the Senate in the 91st and 92d Congresses, but failed final enactment.

B. Major Provisions

S. 386 would provide for Federal operating assistance to mass transit systems. Also provided would be an additional $3 billion in contract authority under the Urban Mass Transportation Assistance Act to sustain the capital grant program through fiscal year 1977.

[8] For additional information on major bills discussed in this section, see Chapter IX, Part One, p. 74.
[9] For additional information on major bills discussed in this section, see Chapter IX, Part One, p. 77.

C. Status as of April 1, 1973

S. 386 was added as an amendment to the Federal Aid Highway Act Amendments (S. 502) which passed the Senate on March 15, 1973.

Housing and Urban Development Act of 1972 (H.R. 16704—S. 3248)

A. Legislative History

H.R. 16704 was introduced by Congressman Patman on September 18, 1972, and referred to the Committee on Banking and Currency. The bill was reported out of committee on September 21, but was not voted on in the House.

B. Major Provisions

Of interest on transportation is an amendment added by Congresswoman Bella Abzug which would have provided that an applicant for a grant or loan under the Urban Mass Transportation Act offer assurances that fares charged to the elderly and handicapped in non-peak hours would not exceed one-half of the general rate. The Senate housing bill (S. 3248) did not, however, include this provision.

C. Status as of April 1, 1973

The Abzug amendment has not been reintroduced during the 93d Congress.

Reduced Airline Fares for Youths and Senior Citizens (S. 181)

A. Legislative History

S. 181 was introduced by Senator Moss on January 4, 1973. An earlier version of this legislation (S. 1808) was also sponsored by Senator Moss during the 92d Congress. S. 1808 authorized reduced air fares for senior citizens on a space-available basis. On September 21, 1972, Senator Moss won approval of an amendment to S. 2280 (the Senate Anti-Hijacking bill). This amendment authorized reduced fares on a space-available basis for individuals age 21 or younger or 65 and older. The Moss amendment was lost, however, because the Conferees were not able to reconcile other differences between the respective Senate and House Anti-Hijacking bills.

B. Major Provisions

S. 181 would authorize reduced fares on airlines for youth (21 years of age and younger) and senior citizens (65 years of age and older) on a space-available basis.

C. Status as of April 1, 1973

Hearings are planned on S. 181 by the Aviation Subcommittee of the Senate Commerce Committee, but no definite dates have been set.

Older Americans Comprehensive Services Amendments

(Transportation provisions in H.R. 15657—S. 4044)

A. Legislative History

(For discussion of legislative history, see p. 100.)

B. Major Provisions

(For description of the special transportation study and demonstration project section, see p. 101.)

C. STATUS AS OF APRIL 1, 1973

(See p. 101.)

X. PROPOSALS RELATING TO CONSUMERS [10]

CONSUMER PRODUCT SAFETY ACT (S. 3419)

A. LEGISLATIVE HISTORY

S. 3419 was introduced by Senator Magnuson on March 24, 1972. The bill passed the Senate on June 21. The House approved similar legislation on September 20. The House and Senate agreed to the conference report on the bill on October 13 and 14, respectively.

B. MAJOR PROVISIONS

The act established a Consumer Product Safety Commission to protect the public from unreasonable risk of injuries associated with consumer products. The Commission is authorized to promulgate product safety standards. The Commission will be assisted in its functions by a Product Safety Advisory Council. Also established is an Injury Information Clearinghouse which will collect, investigate, analyze, and disseminate injury data and information associated with consumer products.

C. STATUS AS OF APRIL 1, 1973

S. 3419 became Public Law 92–573 on October 27, 1972.

CONSUMER PROTECTION ACT OF 1973 (H.R. 21)

A. LEGISLATIVE HISTORY

H.R. 21 was introduced by Representative Holifield on January 3, 1973, and was referred to the Government Operations Committee. The bill is identical to H.R. 10835 which passed the House on October 14, 1971 by a vote of 344 to 44. A related bill in the Senate failed to reach a vote in the closing days of the 92d Congress.

B. MAJOR PROVISIONS

H.R. 21 would create a Consumer Protection Agency to provide representation for consumers and consumer interests before departments and agencies of the Federal Government and the courts. The bill would also provide a statutory basis for the Office of Consumer Affairs, now located in the Executive Office of the President. Also created would be a Consumer Advisory Council so that consumers themselves and persons familiar with their needs could provide advice and guidance to the two above bodies.

C. STATUS AS OF APRIL 1, 1973

H.R. 21 is pending in the House Government Operations Committee. Joint hearings were held on similar legislation (S. 707) by the Senate Commerce Committee and the Government Operations Committee on March 27 and 28.

[10] For additional information on major bills discussed in this section, see Chapter IX, Part One, p. 80.

National No-Fault Motor Vehicle Insurance Act (S. 354)

A. Legislative History

S. 354 was introduced by Senator Magnuson on January 12, 1973, and was referred to the Committee on Commerce. The bill resembles S. 945 which was reported by the Committee on Commerce in the 92d Congress.

B. Major Provisions

S. 354 would create an automobile insurance system which would pay the basic economic loss of persons injured in automobile accidents whether or not they were "at fault." A State plan implementing the proposed Federal legislation would have to provide for severe limitations on cancellation and notice protection for nonrenewal.

C. Status as of April 1, 1973

Hearings were held in February on S. 354, by the Senate Commerce Committee.

Consumer Product Warranties and Federal Trade Commission Improvements Act (S. 356)

A. Legislative History

S. 356 was introduced by Senators Magnuson and Moss on January 12, 1973, and referred to the Committee on Commerce. The bill is similar in content to S. 986 which passed the Senate by a vote of 76 to 2 on November 8, 1971.

B. Major Provisions

S. 356 would (1) provide minimum disclosure standards for written consumer product warranties against defect or malfunction and (2) define minimum Federal content standards for the warranties. The bill would also improve the consumer protection activities of the Federal Trade Commission.

C. Status as of April 1, 1973

S. 356 was scheduled to be acted upon by the Senate Commerce Committee on April 4, 1973.

Vocational Rehabilitation Act (S. 7)

A. Legislative History

H.R. 8395 was pocket vetoed by the President on October 27, 1972. An identical bill, S. 7, was vetoed on March 27, 1973.

B. Major Provisions

Sections 702 and 703 of S. 7 relate to the issue of barriers. The bill would have established a National Commission on Transportation and Housing for Handicapped Individuals to make reports and recommendations on the barriers problems. The National Commission would have acted in consultation with the proposed Architectural and Transportation Barriers Compliance Board. The Compliance Board was designed to add effective enforcement to the Architectural Barriers Act, and would have been an eight department inter-agency cooperative effort. The National Commission would have had representative membership for the private and professional sectors.

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C. Status as of April 1, 1973

S. 7 was awaiting a vote in the Senate to override the Presidential veto. On April 3 the Senate failed (by four votes) to obtain the necessary two-thirds requirement to override the Presidential veto.

XI. PROPOSALS RELATING TO RESEARCH AND TRAINING [11]

Research on Aging Act (S. 887—H.R. 14424)

A. Legislative History

In 1972 the Research on Aging Act (S. 887 and H.R. 14424) was approved by the House on July 18 and the Senate on September 21. On October 30 the President pocket-vetoed the bill. Similar legislation was again reintroduced in the Senate (S. 775) and in the House (H.R. 65) early in 1973. Hearings were held on these proposals by the Public Health and Environment Subcommittee of the House Interstate and Foreign Commerce Committee (on March 16, 1973) and the Subcommittee on Aging of the Senate Labor and Public Welfare Committee (on March 27).

B. Major Provisions

The Research on Aging Act would establish a National Institute on Aging at the National Institutes of Health. The new institute would be responsible for conducting and supporting biomedical, social, and behavioral research and training related to the aging process.

C. Status as of April 1, 1973

The House Public Health and Environmental Subcommittee ordered reported the Research on Aging Act (now H.R. 6175) on March 21, 1973.

Older Americans Comprehensive Services Amendments (Research and Training Provisions in H.R. 15657—S. 4044)

A. Legislative History

(See discussion of Older Americans Comprehensive Services Amendments, p. 100.)

B. Major Provisions

(Amendments affecting research and training are discussed in detail on p. 101.)

C. Status as of April 1, 1973

(See discussion of Older Americans Comprehensive Services Amendments, p. 101.)

XII. PROPOSALS RELATING TO DEATH WITH DIGNITY [12]

Commission on Medical Technology and Dignity of Dying (H.R. 15576)

A. Legislative History

H.R. 15576 was introduced by Representative Carter on June 19, 1972. It was referred to the Committee on Interstate and Foreign Commerce. No hearings were held on the bill.

[11] For additional information on major bills discussed in this section, see Chapter X, Part One, p. 84.
[12] For additional information on major bills discussed in this section, see Chapter X, Part One, p. 86.

B. Major Provisions

H.R. 15576 would establish a Commission on Medical Technology and Dignity of Dying which would study under what circumstances modern medical technology is being used to deny individuals the right to die with dignity, and under what circumstances Government funds prohibit the right to die with dignity and what are the costs of maintaining individual cases of support. The Commission would make recommendations on its findings.

C. Status as of April 1, 1973

Similar legislation (H.R. 2655) was reintroduced on January 23, 1973. This bill has been referred to the House Interstate and Foreign Commerce Committee, where it is pending.

XIII. PROPOSALS RELATING TO THE RURAL ELDERLY [13]

Older Americans Home Repair Assistance Act (S. 2888)

A. Legislative History

Senator Church introduced S. 2888 (the Older Americans Home Repair Assistance Act) on November 19, 1971. The bill was originally referred to the Senate Banking, Housing and Urban Affairs Committee and then re-referred to the Senate Labor and Public Welfare Committee.

B. Major Provisions

S. 2888 would make a wide range of home repair services available to elderly homeowners who otherwise would have difficulty in paying for these services. Supplies and material would be furnished by the aged homeowner, but the labor would be provided without charge.

C. Status as of April 1, 1973

Senator Church reintroduced the Older Americans Home Repair Assistance Act (S. 633) on January 31, 1973. The bill has been referred to the Labor and Public Welfare Committee.

Older Workers Conservation Corps Act (S. 3208)

A. Legislative History

Senator Humphrey introduced the Older Workers Conservation Corps Act (S. 3208) on February 22, 1972. The bill was referred to the Senate Labor and Public Welfare Committee, but no final action was taken on this legislation.

B. Major Provisions

S. 3208 would authorize $150 million for fiscal 1974 to promote useful part-time work opportunities in conservation and environmental improvement activities for unemployed persons who are 55 years or older. Some of the activities performed by this conservation corps would include conservation of natural resources, environmental improvement, beautification, and community development projects.

C. Status as of April 1, 1973

Senator Humphrey reintroduced the Older Workers Conservation Corps Act (S. 1168) on March 12, 1973.

[13] For additional information on major bills discussed in this section, see Chapter X, Part One, p. 87.

XIV. PROPOSALS RELATING TO OEO PROGRAMS [14]

ECONOMIC OPPORTUNITY ACT AMENDMENTS OF 1972 (H.R. 12350)

A. LEGISLATIVE HISTORY

The 1972 Economic Opportunity Act Amendments were approved by the House on February 17, 1972, and the Senate on June 29. The Senate and the House agreed to the conference report on September 5. H.R. 12350 was signed into law (P.L. 92–424) on September 19, 1972.

B. MAJOR PROVISIONS

Public Law 92–424 increased the recommended authorization for the Senior Opportunities and Services program to $18 million for fiscal 1974. Moreover, the 1972 amendments authorized the Director to enter into contracts with private nonprofit organizations to provide services for certain target groups (such as the elderly) not being effectively served under Title II (Urban and Rural Community Action Programs) of the act.

C. STATUS AS OF APRIL 1, 1973

H.R. 12350 became Public Law 92–424 on September 19, 1972. Furthermore, the 1973 Older Americans Comprehensive Services Amendments (S. 50 and H.R. 71) include a provision to provide an additional $7 million authorization for Senior Opportunities and Services programs for fiscal years 1973 and 1974.

XV. PROPOSALS RELATED TO MODEL CITIES [15]

BETTER COMMUNITIES ACT

A. LEGISLATIVE HISTORY

The fiscal year 1974 budget does not call for any new appropriations for Model Cities. The administration plans to phase the program out along with six other categorical programs: Open Space Land, Urban Renewal, Neighborhood Facilities, Water and Sewer Facilities, Rehabilitation Loans, and Public Facility Loans. All these programs would be eligible for funding under the proposed Better Communities Act.

B. MAJOR PROVISIONS

The Better Communities Act is a special revenue sharing act to fund community development. Model Cities and the other six programs mentioned above would be folded into this program at the local option.

C. STATUS AS OF APRIL 1, 1973

The Better Communities Act has not been introduced to the Congress, but it is expected shortly.

[14] For additional information on major bills discussed in this section, see Chapter X, Part One, p. 88.
[15] For additional information on major bills discussed in this section, see Chapter X, Part One, p. 91.

XVI. PROPOSALS RELATING TO LEGAL SERVICES [16]

National Legal Services Corporation (Mondale Amendment)

A. Legislative History

Senator Mondale introduced Amendment No. 5 to S. 706 (Economic Opportunity Act Amendments) on February 1, 1973. Amendment No. 5 would establish a National Legal Services Corporation, patterned after the provisions contained in section 27 of the conference report on H.R. 12350, the 1972 Economic Opportunity Act Amendments. Section 27 was later deleted from the conference report on the 1972 OEO amendments. Amendment No. 5 has been referred to the Subcommittee on Employment, Manpower and Poverty of the Senate Labor and Public Welfare Committee.

B. Major Provisions

Amendment No. 5 would create a 19 member National Legal Services Corporation to be appointed by the President with the advice and consent of the Senate. Ten of the appointees would be from the general public and the remaining nine members would include:

—Five individuals representative of the organized bar and legal education;

—Two persons representative of clients' interests; and

—Two former legal services project directors.

The Mondale amendment would authorize $121.5 million for fiscal 1974 to carry out the functions of the Corporation.

C. Status as of April 1, 1973

Amendment No. 5 is pending before the Subcommittee on Employment, Manpower, and Poverty of the Senate Labor and Public Welfare Committee

[16] For additional information on major bills discussed in this section, see Chapter X, Part One, p. 89.

MINORITY VIEWS

MINORITY VIEWS OF MESSRS. FONG, HANSEN, GURNEY, SAXBE, BROOKE, PERCY, STAFFORD, BEALL, AND DOMENICI

INTRODUCTION

National responses to needs of older Americans during the 15 month period with which this Special Committee on Aging annual report is concerned have been a mixture of successes, half-successes, failures, frustrations and new hopes for the future.

Continuing the forward movement of recent years, 1972 brought substantial progress, particularly through Social Security and Railroad Retirement benefit increases, in making more adequate incomes immediately available to most older persons.

No less significant in 1972 was approval of the Federal Supplementary Security Income program which begins next year. Properly implemented, this new Federal approach to minimum income assurance should be a dramatic step forward in our efforts to eliminate severest economic hardships among persons past 65.

In a number of other specifics, such as appropriate tax relief measures, 1972 legislative action ignored or fell short of equity. There remain a number of proposals for immediate improvements in the economic situations of older persons, therefore, which deserve early responses by the present Congress.

Legislation to improve private pension plans is one area on which action has not yet been completed, but which gives promise of action soon. As a long range step on behalf of future retirees, this legislation can be important in preventing serious problems which have confronted some of today's elderly.

Paramount among economic problems of older Americans, of course, is the destructive nature of inflation. That this hidden and sometimes massive tax strikes hardest at the old and the poor is self-evident.

Despite progress in limiting the inflationary spiral rate, which regrettably and perhaps inevitably has been characterized by momentary successes and failures, it remains the most serious and universal problem faced by older America.

Solution of the inflation spiral problem requires effective cooperation between legislative and executive branches of Government.

Cooperation between the Congress and the Administration is equally necessary to effective and properly directed improvements in social programs for older persons.

1972 SOCIAL SECURITY GAINS

Elsewhere in this committee report there appears a detailed discussion of legislative progress in aging during the past year. Certain highlights of these forward steps, however, deserve repetition and special comment in these minority views.

Enactment of a 20-percent increase and provision for automatic cost-of-living adjustments in Old-Age, Survivors and Disability Insurance cash benefits as part of Public Law 92–336, and other improvements in the Social Security Act through Public Law 92–603, both of which were promptly signed by the President, made 1972 a landmark year in Federal legislation on behalf of older Americans, especially with regard to their economic security.

Action on the 20-percent benefit increase and automatic cost-of-living adjustments were on an amendment to the debt limitation bill. This amendment was introduced by Senator Frank Church, Chairman of the Special Committee on Aging. As noted elsewhere in this report the Senate vote on the Church amendment was 82 for and 4 against. Final passage and Presidential approval of the measure culminated a four year record of gains in Social Security benefits of over 50 percent, far in excess of any similar time period since enactment of the original law.

The automatic living cost adjustment provision concluded an effort which began over eight years ago with a strong minority recommendation within this committee's annual report.

Public Law 92–603, the Social Security Amendments of 1972, introduced by Chairman Wilbur Mills of the Ways and Means Committee of the House of Representatives, contained numerous other improvements in the Social Security Act recommended by the President. The Senate vote on this measure was 68 for and 5 against.

This proposal had originally contained general Social Security increase and automatic cost-of-living adjustment provisions which were dropped because of their prior enactment as part of the Church amendment to Public Law 92–336.

Among numerous new provisions now in effect under the Social Security Amendments of 1972, some are of special immediate importance to persons past 65. They include:

1. Increase in benefits to widows (and widowers) from 82½ percent to 100 percent of the primary old-age insurance entitlement.
2. Higher minimum old-age insurance benefits ($110.50 to $170 monthly) for persons with over 22 years covered employment.
3. Liberalization of the retirement test so as to permit earnings by Social Security beneficiaries up to $2,100 annually without penalty, and modification of penalties imposed thereafter.
4. Voluntary Medicare enrollment privileges by otherwise ineligible persons 65 and over on payment of costs of such coverage.

The widows benefit increase, which gives the same level benefits to a surviving spouse regardless of whether he or she obtained entitlement as a covered worker or as a dependent, corrects an inequity which has long called for action.

It is particularly significant because it has been recognized for years that the severest economic problems in older America, apart from those encountered by racial or ethnic minorities, are those faced by older women. Their generally lower income opportunities and expectations of longer life have combined to make them particularly vulnerable economically.

Slightly less than 4 million persons are receiving increases through this commendable action which has long been advocated by members of this Committee. Coupled with the general 20 percent increase for

all Social Security beneficiaries, the change produced a total benefit increase for older widows during 1972 of almost 40 percent.

While affecting a much smaller number of persons (150,000), the new special minimum cash benefit provisions for persons with long attachment to the Social Security covered work force will be important in strengthening the income position of retirees with extremely low earnings during their working years. The new computation method provides minimum benefits of $110.50 monthly for persons with 23 years covered employment and increments of $8.50 monthly for each additional year up to $170 monthly with 30 years or more of covered employment.

The new special minimum benefits schedule represents a compromise between a lower schedule originally passed by the House and a higher one approved by the Senate. Had the Senate version prevailed, the minimum benefit after 23 years coverage would have been $130 monthly and the increments would have been $10 for each additional year up to $200 monthly for persons with 30 years or more coverage. The Senate bill would have helped 1.3 million persons including much larger numbers of persons in minority groups whose low earnings have been a product of long time discrimination.

A deficiency in this new provision is exclusion of such minimum benefit calculations from automatic cost-of-living adjustments. We recommend that prompt consideration be given to correction of this short-coming in the interest of consistency, particularly since the cost would be modest.

Despite its deficiencies, this new approach to needs of low income persons with long attachment to Social Security as contributors is a refreshing, innovational concept on which we hope future improvements in minimum benefits may be built.

Social Security gains as a whole during 1972 have vastly strengthened the system's role as a floor of protection for older Americans. The extent of progress is indicated by recent H.E.W. estimates that the percentage of persons past 65 below the official poverty line has been reduced sharply to 15 percent of the people in this age group, a figure roughly comparable to the percentage for younger people.

For both groups the percentage remains too high, but in both instances it represents substantial progress over the situation but a few years ago. The new Federal Supplementary Income program, to begin in 1974 and discussed subsequently in these minority views, should reduce the percentage of older Americans in poverty still more—hopefully to almost zero.

LIBERALIZATION OF SOCIAL SECURITY EARNINGS PENALTIES

The Public Law 96–603 change in the retirement test which raises the amount of earnings a Social Security beneficiary may receive without loss of benefits from $1,680 per year to $2,100 and which provides for a reduction in benefits of $1 for each $2 of earnings above $2,100 (in contrast to the $1-for-$1 reduction under the old law for all earnings in excess of $2,880) was both welcome and overdue.

Even as now devised, however, the Social Security retirement test still imposes penalties that are excessively harsh on those between the ages of 65 and 72 who prefer to work part-time or full-time to supplement their retirement income.

To older Americans these penalties on those who want to work is one of the most objectionable features in the Social Security system as now constituted. Their propriety on both economic and social grounds has been challenged repeatedly. While much has been made of the "high cost" to the Social Security system of the retirement test's elimination, there has been no serious or valid effort made to determine the actual costs of its retention to older persons and to the nation through loss of wealth from non-use of their skills.

It should be noted that the 1972 liberalization was the first since the Social Security Amendments of 1967. During this time there were three general Social Security increases which totaled in excess of 50 percent. The fact that the amount of earnings not subject to penalties has been increased only 25 percent emphasizes how increasingly inequitable the retirement test has become.

While ultimate total elimination of the earnings test deserves serious consideration, we believe that at least $3,000 earnings should be made exempt from penalty as quickly as possible. The Senate has twice approved such a liberalization only to have it lost in conference with the House of Representatives. We recommend that efforts be continued with vigor to attain this figure as a bare minimum in equity on behalf of older Americans who choose to work.

VOLUNTARY MEDICARE COVERAGE

In the Social Security Amendments of 1972 there were almost 100 changes in Medicare and Medicaid programs designed to improve their effectiveness in meeting health care needs. Those of particular interest to older persons are discussed fully elsewhere in this report. Among these, action to permit persons over 65 to enroll voluntarily in Medicare if not covered by Social Security and therefore ineligible to participate in the program, was especially noteworthy.

With the preemption of basic health insurance for older persons by Medicare in 1965, opportunities for purchase of private insurance comparable in scope of benefits has become increasingly difficult for persons past 65. The new voluntary enrollment plan therefore is a welcome device to help hundreds of thousands of older persons to participate in the Medicare program who had found their ability to budget for health care costs in special jeopardy.

We regret that an equally important proposal, introduced by Senator Edward J. Gurney, to permit voluntary enrollment in Medicare by persons between the ages of 60 and 65 who are married to Medicare beneficiaries, was not included in P.L. 92-603 on final passage. Senator Gurney's amendment which was approved by the Senate, but dropped by the Senate-House conference, represented an effort to facilitate decent health insurance coverage for couples one of whom is ineligible for Medicare by reason of age.

We recommend early adoption of this voluntary enrollment proposal, which would cost the taxpayer nothing, in the interest of avoiding unjustifiable costs of health insurance for older families which inevitably result where coverage is obtained through separate individual insurance plans.

OLDER AMERICANS INCOME ASSURANCE PLAN

Beginning next January a new National Supplementary Security Income for the Aged, Blind and Disabled will begin operation under direction of the Social Security Administration.

Under its provisions, which were recommended by the President and enacted as part of the Social Security Amendments of 1972, older Americans and blind or disabled persons for the first time in our history will be assured a guaranteed minimum annual income by the Federal Government. Such minimums will be assured regardless of entitlement or lack of entitlement to Social Security or other income maintenance programs.

Payments to eligible persons will be made by the Social Security Administration from Federal funds in amounts which, together with other income, will bring individual's or couple's total income up to the new minimum national standard.

The intent of the Supplementary Security Income plan is two-fold. It will guarantee to persons over 65, the blind and the disabled the full benefit of the Federal income supplement money regardless of where in the United States they may live. It will do so with minimum red tape and maximum recognition of the rights of beneficiaries to economic help with honor and dignity.

By avoiding windfalls to persons with adequate incomes from other sources, it will raise minimum income standards for all older persons and others it will serve without excessive burdens on the taxpayers.

While it will provide technical minimums of $130 and $195 a month respectively for individuals and couples, the normal minimum incomes assured under the plan will be at higher levels.

For the vast majority of persons past 65—all of those who receive Social Security payments—minimum incomes will be at least $150 a month for individuals and $215 for couples. This comes from the disregard of the first $20 of Social Security benefits in calculating the amount of the Federal supplement.

Disregard also of all of the first $65 a month of money earned through employment, and half of monthly earnings in excess of $65, means that for many persons past 65 the income at their disposal under the plan will be at least $215 monthly for an individual and $280 for a couple.

For residents of most States, the typical income levels under the National Supplementary Security Income program will exceed normal maximums permitted under current Old Age Assistance programs, and it will do so without loss of individual dignity which has prompted sharp criticism of the latter.

All States will be permitted under the plan to supplement the Federal program. This may be done through the State's own separate supplemental program or through contributing to the national plan with the Federal Government absorbing administrative costs.

If every State provides such voluntary supplements in the same amount as it now budgets its share of Old Age Assistance, virtually every person past 65 will be eligible for higher income supplements—usually substantially higher—than at present.

We strongly urge every State to take prompt steps to join with the Federal Government in action to make maximum use of the Supplementary Security Income program in eliminating poverty among the aged, blind and disabled persons who reside within it.

We are particularly pleased at this new development for income adequacy among older persons because the program, as adopted, is patterned after the Older Americans Income Assurance Act proposal introduced in the 90th Congress by the late Senator Winston L. Prouty, then a member of this Committee, and endorsed in the Committee's minority reports since that time.

As envisioned then, and subsequently implemented by Congress in Public Law 92–603, it was felt that older Americans who require economic help prefer *direct income with dignity* to such specialized and limited assistance devices as food stamps, helpful as the latter have been as stop-gap alternatives to cash in the past. Income payments will avoid the onus in the marketplace which many older persons have found distasteful in the food stamp program.

OLDER AMERICANS SERVICES AMENDMENTS

The enactment of the Comprehensive Older Americans Services Amendments of 1973, April 18, and assurances of its prompt approval by the President represents a major step toward achievement of the intent of Congress when it first passed the Older Americans Act of 1965 and thereby created the Administration on Aging.

Details of this extension and strengthening of the Older Americans Act are discussed elsewhere in this report. To those who have followed this legislation carefully, however, it is obvious that success in this effort on behalf of older Americans required a strong cooperative concern for them by the Congress and the Administration.

We are particularly gratified at the higher visibility and presumably more important role which will result for the Administration on Aging and its activities on behalf of older persons.

Increased funding for Administration on Aging activities—including the elderly nutrition program and expanded services at State and community levels—for the Retired Senior Volunteers Program and Foster Grandparents under ACTION, and for expanded employment services under the Department of Labor, which are confirmed by the Older Americans Services Amendments should strengthen Federal efforts on behalf of concepts originally enunciated in the Older Americans Act. So too will assignment of higher status to the Commissioner on Aging within H.E.W.

We are especially pleased by the bipartisan spirit which prevailed during consideration of the Comprehensive Older Americans Services Amendments of 1973. This cooperation, aimed at making a significant contribution to the welfare of America's older people, marked deliberations of the Senate's Subcommittee on Aging, the Education and Labor Committee of the House of Representatives, as well as negotiations which led to a successful agreement between the Congress and the White House on this measure. The success of the negotiations between the legislative and executive branches can be seen in the fairness of the compromise which preserved the President's desire to curb inflationary pressures while upholding many of the Congressional initiatives designed to expand the Federal program for the aging.

Senator J. Glenn Beall, the Ranking Minority Member on the Labor and Public Welfare Committee's Subcommittee on Aging, and Congressman Albert H. Quie, the Ranking Minority Member on the Education and Labor Committee, played significant roles in negoti-

ating agreement with the White House. Senator Thomas F. Eagleton, speaking in his capacity as Chairman of the Subcommittee on Aging stated—

> I would again like to note that the Ranking Minority Member of our Aging Subcommittee, Senator Beall, had continued the spirit of cooperation that had characterized our work heretofore. His contribution can be seen throughout the bill and his assistance was vital in achieving the accord we have reached with the President.

Needless to say accommodation of differing views would have been impossible without the painstaking efforts of Senator Eagleton and Congressman John Brademas, Chairman of the House Education and Labor Committee's Select Education Subcommittee.

A development which may have no less an impact on long-range and immediate progress toward higher visibility to needs of older persons and greater coordination among aging programs within the Federal apparatus, was the President's recent nomination of Dr. Arthur S. Flemming as Commissioner on Aging.

We urge prompt confirmation of Dr. Flemming's appointment with confidence that it will receive fully bi-partisan support.

In addition to serving as Commissioner on Aging, Dr. Flemming will work with Health, Education and Welfare Secretary Casper W. Weinberger, in the latter's capacity as counsellor to the President for Human Resources, in coordinating aging programs across the government. He will also continue to be involved in consideration of policy matters affecting the aging at the White House level.

Dr. Flemming's long record, as well as his distinguished service as Chairman of the 1971 White House Conference on Aging, makes his nomination as Commissioner on Aging a most fortuitous one.

Dr. Flemming's personal stature gives promise that, at long last, the Administration on Aging may become the strong focal point in government that it was originally intended to be.

Dr. Flemming's service as Chairman of the recent White House Conference on Aging and his subsequent activities in promotion of its recommendations have been widely acclaimed. His strong commitment to positive responses in aging, however, goes back to an earlier period in his career of public service.

As Secretary of Health, Education and Welfare during the second Eisenhower Administration, Dr. Flemming was most important in developing new national awareness of older America's needs. He established the Office of Aging in H.E.W. and through it gave sharp new emphasis to challenges and problems in aging. It was under his direction that the first White House Conference on Aging was held in 1961. That the Eisenhower conference is often described as the real beginning of new national attitudes toward age and older people is a credit to Dr. Flemming's leadership, even as has been his role in the 1971 conference.

At the same time we recognize that the benefits of Dr. Flemming's leadership will require vigorous support. We urge that the Congress and the Administration continue to join together in providing Commissioner Flemming with the tools he will need in his new assignment.

INFLATION—STILL PROBLEM NO. 1

Twelve years ago, when federal income maintenance programs for the elderly were far inferior to those of today, the first Special Committee on Aging report emphasized the extreme importance of inflation as a factor in aging. Today it is still the most serious and universal economic problem faced by older persons. It remains older America's No. 1 Public Enemy.

Despite the Nation's progress during the past 4 years in limiting inflation, in a world where with rare exceptions rising living costs are commonplace, the hidden tax levied through spiralling prices remains most serious.

This fact is currently being brought home most forcefully because we are confronted with a new inflationary crisis. That the complexity of this economic problem almost inevitably foreordains that the pattern of progress will be interspersed with temporary setbacks, in no way diminishes the pain which such economic adversities impose.

Nor is there much comfort to the individual, who is trying to buy necessities of life with a dollar of diminished value, that inflation control in this country has been more effective than elsewhere in the world. During 1972, the last year for which valid estimates are available, the United States inflation rate was 3.3 percent; among other nations for which such figures are available the annual inflation rate percentages were as follows: Australia, 5.9; Belgium, 5.2; Canada, 4.8; France 5.6; Germany, 5.8; Italy, 5.4; Japan, 4.8; the Netherlands, 7.8; South Africa, 6.5; Sweden, 6.2; Switzerland, 6.6; and the United Kingdom, 7.0.

Of these nations only France, Japan, and the Netherlands had lowered their inflation rate beneath that which prevailed in 1969. In the United States the reduction during this period was from 5.4 percent to the 1972 3.3 percent level.

We could console ourselves with these comparative statistics, but it is is not enough to say that the problem could be worse. As a Nation we must take every reasonable step now to solve the massive problem which inflation presents. We strongly endorse recent expressions of intent within the Congress and elsewhere in the Federal Government to act on this problem without delay.

It is not the province of this Committee report to engage in a comprehensive review of all of the complicated factors which contribute to inflation. Certain general comments appear appropriate, however, because of the question's extreme importance to older Americans.

No one would deny that mistakes, particularly in efforts to treat the *symptoms* of inflation have been made in the battle to re-establish and preserve the dollar's purchasing power. But *ultimate victory in the war against inflation requires positive action on its basic causes.*

One key factor to which reference has been made repeatedly in our minority reports of previous years is the extent to which Congress appropriates money for expenditures beyond reasonable capabilities of our Nation. When appropriations substantially exceed the tax burdens we are willing or able to impose, it is elementary that there will be a loss in dollar values.

We are pleased that the Congress appears determined to abandon excessive spending of the past in response to the threat which faces America. Since the Administration has insisted on a new era of fiscal responsibility within the Federal Government, we now have reason to hope that this basic step necessary to inflation control will be taken.

Congressional actions in response to the key elements underlying rising living costs, however, can extend beyond exercise of fiscal responsibility. They can well include legislation aimed at other root causes of the problem.

An example of the latter is afforded by the opportunity to support efforts of the Administration to re-shape American farm policy from one of calculated scarcity to productive abundance. It illustrates the kinds of basic national policy changes that effective responses to the challenge of inflation may require. It underscores the complex nature of and the varied elements in the problem.

That the President's farm program is being pushed at a time when sharp increases in food prices are causing legitimate anguish among all Americans, may augur well for its approval.

The purposes and promises of this major effort to stop the rise in food prices, and some of the problems, are indicated in two recent articles which recently appeared in *The Washington Post.*

The first, under date of April 8, by Joseph R. Slevin, said in part:

> President Nixon is dramatically changing the course of American farm policy and old-time residents of the Federal City cannot quite believe it is happening.
>
> He is rejecting planned scarcity in favor of abundance and is telling the nation's farmers that the way to boost their incomes is to increase their production.
>
> It is a complete reversal of the restrictive agricultural policies that have been in effect for the past 40 years that were symbolized during the Franklin Roosevelt Administration by the controversy over the plowing under of little pigs.
>
> Nixon started his farm revolution with the 1970 Agricultural Act and he will battle to carry it further in the 1973 Act. . .
>
> Council of Economic Advisers chairman Herbert Stein said recently that he has not seen anything like the agricultural policy shift during the 30 years he has been a resident of the capital. "I am amazed at the extent to which we have been able to turn farm programs around," he declared.
>
> The emergency measures Nixon has been taking in recent months are one dramatic package. His proposals for new legislation are another.
>
> The President suspended meat import quotas and asked Congress to remove the meat tariff and nobody said "boo". He proposed a 50 percent boost in cheese import quotas and is selling off the surplus grains that once choked farm belt elevators. The government sold its last wheat in March and has only a small amount of corn still on hand.
>
> In a move to relieve the meat shortage, farmers have been given permission to use their set-aside acres for grazing and for harvesting winter feed . . .

For all practical purposes, Nixon has removed most constraints on 1973 crop production.

A side benefit will be a cut in government payments to farmers . . .

Nixon's new farm program will provide that future set-aside payments are to be cut and that payments to farmers are to drop proportionately as the number of set-aside acres goes down.

The scarcity philosophy called for high payments to encourage farmers to divert acreage from production. The abundance approach is designed to encourage farmers to put their land into production.

Rigid, high price supports are to be replaced with lower supports that will lead a farmer to give his crop to the government only in an unusual year of huge surpluses and collapsing prices.

Farmers will have every incentive to plant fence to fence in a shortage year.

The second *Washington Post* article, which appeared April 9, and was written by George C. Wilson, included the following:

The Iowa farmer (Roswell Garst) who sold seed-corn to Khrushchev back in the 1950's slapped a pamphlet down on the desk and declared that nobody—least of all someone from Washington—could understand meat prices or anything else about agriculture these days until after he had read it . . .

As it turned out, the pamphlet contained some points bearing on the current meat boycott and the international dynamic that could frustrate it. Items:

- It now seems certain that by July 1, 1973, world stocks of grain will be at the lowest points since 1965. Despite a tremendous expansion in these crops, it said, the world demand for food grains for cattle, hogs and chickens keeps going up as people everywhere demand more meat, eggs, milk and cheese.
- Few farmers, and almost no nonfarmers, realize that the per capita consumption of beef in the U.S.A. has almost doubled since 1950—from 63.4 pounds in 1959 to 115 pounds in 1971.
- With both the number of people in the United States and the amount of meat they eat increasing, the only way to satisfy that demand is to increase sharply the number of beef cattle on the nation's ranges and in feed lots where they are fattened up for market. But no such rapid expansion is yet underway. Iowa and Michigan are the only two states that increased their beef cattle population by more than 15 percent between 1970 and 1972, and it takes time to build up herds . . .
- For the short term, the Nixon administration has scrapped last year's restrictions holding some 60 million acres of land out of production and told farmers to go ahead and use all but about 8 million acres of it.

• For the longer term, both the administration and Congress are grappling with legislation to take over when the Agriculture Act of 1970 expires this year.

Senator Hubert H. Humphrey (D–Minn.) believes more than just another farm bill can be written this year. He believes that American wheat, corn and other farm produce—if handled properly—could entice Soviet leaders into agreeing to mutual arms reductions.

Senator Humphrey's view, reported above, illustrates how seemingly disparate elements in the inflation problem can interlock. Success in mutual arms reduction, another high priority national goal, of course can also be a factor in Federal expenditures and price stability.

That inflation control is one of the most important actions which the Federal Government may now take has been repeatedly emphasized by older Americans themselves. They understand that the one element in their lives to which the Federal Government can be most responsive, for good or ill, is in strengthening and maintaining their economic power. Health care, housing, and every other physical human need ultimately requires money.

To the extent that older Americans have money, and money which keeps its value year after year, they have the basic key to personal independence.

Older Americans know too that no one is hit harder by the ravages of inflation than the old and the poor, and that the poor elderly are hardest hit of all.

EXTENSIVE PROBLEMS REMAIN

In Parts One and Two of this committee report there is an extensive review of events in aging which have occurred since the 1971 White House Conference on Aging and numerous unresolved questions in the development of satisfactory national policies in aging. The information this review offers, together with testimony which has been presented before congressional committees which have legislative responsibility in the several fields, should be of great help to the Congress and the Administration in their joint efforts to improve quality of life for all older Americans.

It is evident that unsolved problems for many of those in our aging population are extensive and varied in nature. It is equally evident that assignments of priorities in money, time and effort is not a simple process. This is especially true if we give recognition to the limits of tax burdens which may properly be imposed on young or old.

It is fitting here to comment, in general terms, on some of the broad recommendations we have made in previous minority reports and which we still feel deserve high priority for action by the Congress.

We recommend vigorous efforts to expand and improve the Nation's unique private pension system.

Elsewhere in this committee report the status of major pension legislation is discussed at some length. We share the hope that positive action will be forthcoming early during the present Congress.

Because both strengthening and expanding private pension programs is desirable, it is important that the final legislation which emerges

achieves balance between appropriate regulation and maintenance of freedom for the system to grow.

Certainly it is imperative that assurances be given that all private pension plans will be financially sound and thus able to deliver on the promise they offer to the participating individual. It seems equally desirable that appropriate steps be taken to assure vesting so that reasonable benefits be available at retirement time notwithstanding some changes in employment by the covered worker. At the same time as consideration is given a number of other desirable improvements in plan operations, it is important that care be exercised to assure that over-regulation does not impede or stop the growth in the system which is extending its benefits to more and more people each year.

We recommend expansion of job opportunities, full time and part time, for older persons desiring employment, and expansion of "second career" and voluntary service opportunities to enable continued involvement of retirees in the mainstream of community life.

Both social and economic needs of older persons demand that they retain the right and opportunity at all ages to enjoy the satisfactions which come from useful and productive roles in society. This is true whether for pay or on a volunteer basis. Society has a responsibility to bring discrimination based on age to a halt.

With reference to employment opportunities, it is no less important that unrealistic impediments to the economic fruits of work, such as the penalties against earnings by Social Security beneficiaries, be modified so as to make it worthwhile for those who want to work to do so. *As noted earlier in these views, we urge immediate liberalization of the retirement test to permit unpenalized earnings up to $3,000 annually.*

"Second career" and volunteer service activities depend in considerable measure on programs especially designed to encourage these activities. They require adequate funding and we endorse the trend in which both the Congress and the Administration have participated in recent years toward increased opportunities of this type.

We recommend restoration of full deductibility for medical and drug expenses from older persons' incomes subject to Federal taxation.

The thrust of this recommendation, which will be of particular benefit to persons past 65 who do not have eligibility for Medicaid, is to restore the full deductibility of medical expenses borne by individuals past 65 as was provided in the Federal income tax law prior to 1967. This full deductibility was eliminated as part of the original Medicare law passed in 1965.

Experience with Medicare since, as discussed elsewhere in this report, indicates that the need for such tax relief remains almost as high today as it was prior to 1967. This proposal for relief of older persons from some of the burdens of health care costs is simple, effective, and could be instituted with minimum delay while we are engaged in implementing other programmatic changes.

We recommend removal of the present requirement that a Medicare beneficiary must necessarily have 3 days of prior hospitalization to be eligible for admission to an extended care facility.

We recommend provision of an unlimited institutional medical care benefit for all persons over a specified advanced age, such as 80 years.

These two recommendations together are offered as first steps in meeting two serious gaps in Medicare's ability to provide necessary care to the elderly, expecially those of most advanced age.

Among the numerous changes in Medicare and Medicaid enacted as part of the Social Security Amendments of 1972 in Public Law 92–603, were modifications in definitions of extended care services under Medicare and skilled nursing services under Medicaid. These broadened definitions did so in ways which make retention of the three day prior hospitalization requirement much less justifiable than may have been the case previously because they gave new recognition to the need for services in cases of serious stabilized chronic illness.

While a technical review of the changed definitions here would serve little purpose, we believe that reduced justification of prior hospitalization is indicated by the following single paragraph from the Senate Finance Committee's report which offered a guide to interpretation of the post-1972 definition of extended care. It said:

> Since the principal aspect of covered care relates to the skilled services being rendered, the restorative potential of the patient is not controlling. Many patients who have no potential for rehabilitation require a level of care which is covered under the program. For example, a terminal cancer patient whose life expectancy is not more than a few months who requires palliative treatment, periodic "tapping" to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort is receiving care covered by this definition. Thus, the controlling factor in determining whether a person is receiving covered care is the skill and frequency involved and the supervision that the patient requires, rather than considerations such as diagnosis, type of condition, or degree of functional limitation.

Also supporting the thesis that prior hospitalization should not be an absolute requisite of extended care services is another provision in the Social Security Amendments of 1972 establishing professional standards review organizations. With effective professional review procedures, the risk of inappropriate admissions to extended care facilities without prior hospitalization should be greatly reduced.

Elimination of the hospitalization requirement when there is adequate medical certification may in some cases provide a fully satisfactory level of care at lower costs.

Our recommendation for development of automatic eligibility for unlimited institutional care for persons of most advanced age is offered as part of a realistic view of the types of medical problems which may be faced by extremely old persons, many of which are not provided for under the program at present. In so recommending we are neither suggesting that all persons of great age have serious medical problems, nor that institutionalization is necessarily appropriate for those who have them, but with the thought that no barriers to such care should exist at that advanced point in life.

We recommend improved Federal support for private elderly housing under mortgage insurance, direct loans and interest subsidy programs and modifications in public housing programs to make them more responsive to special needs of older persons.

We are sensitive to the fears for effective housing of the elderly which have developed as a result of the Administration's freeze, which is discussed at some length in the chapter on housing elsewhere in this committee report. Our concern is mitigated by the Administration assurances that the freeze will not stop or seriously reduce actual delivery of housing.

In view of the housing freeze, we urge that the time interval which it offers be used in a conciliatory spirit by all parties to achieve the Administration's stated purposes of getting the programs into good operating order, removing inefficiencies and red tape which ultimately cost housing sponsors large sums of money, and giving new direction to the programs so that they will indeed provide maximum housing benefits to those who need help from the Federal Government.

For more than five years no observer of elderly housing in America could help but be disturbed about failures of many programs in the Federal system to meet their stated objectives. Housing sponsors have long been beset by regulations and administrative decisions which seriously impede their ability to get the job done. The expected elderly beneficiaries of Federal housing programs have been the victims of delays and higher costs which have resulted. The latter also have been a disservice to the taxpayer. It is truly time to take a good hard look at where we go now in housing for the elderly.

Construction and operational funding of housing suitable for older Americans, which can be offered to them at rentals within reach of their pocketbooks, deserves high priority. Hearings by the Subcommittee on Housing for the Elderly, referred to elsewhere in this report, however, shows that needs go beyond bricks and mortar or even services within housing projects. Adequate provision for safety of person is also extremely important.

Fire hazards and crime jeopardy in housing for the elderly most appropriately have been a major concern of this committee.

Hearings on fire safety, including those related to the tragedy at Baptist Towers in Atlanta, which was regarded as a safe-construction high rise project, show that much needs to be done in provision of protective measures against tragic loss of life. The problems may be complex, but this in no way justifies failure to act.

The serious problems related to protection against criminal elements which are faced by many older persons, particularly in public housing projects, is also of deep concern to us. Adequate security provisions within projects, and location of housing outside of high crime rate areas, obviously are part of the response to this need. Despite the value of such specific steps, however, the ultimate answer in large measure depends on our total effort to reduce crime. Only in this way can either young or old have freedom to live in neighborhoods of their choice.

Testimony before this Committee by Federal law enforcement authorities indicates full awareness of the problem's magnitude and firm intentions to meet it through programs supportive of local law enforcement officials.

That progress is being made is shown by crime statistics since 1968, when the rate of crime increases hit its peak. In each year since, the rate of increase has been reduced until 1972 when, for the first time in 17 years, there was an actual reduction in serious crime.

The 3 percent crime reduction for last year still leaves the national crime rate far too high. It demonstrates, however, that progress can be made. The promise this gain offers must be pursued vigorously through continued and expanded efforts at all levels of government.

We recommend prompt action to stimulate property tax relief measures for older persons through appropriate Federal legislative initiatives as well as direct action by State and local governments.

With between two-thirds and three-fourths of the nation's older couples and many single older persons owning their own homes, probably the most wide-spread problem bearing on housing to which legislation can be addressed is that related to the increasingly serious problem of rising property taxes.

The President has indicated his desire for Federal legislation to relieve all homeowners of part of the heavy property tax burdens which they now must pay. He has singled out the older homeowner as being in special need of property tax relief. Certainly this view is shared by members of the Special Committee on Aging.

The President's proposal for *tax credits* against property taxes, included in his tax reform package for enactment by Congress, was presented to the House Ways and Means Committee April 30 by Treasury Secretary George P. Schultz. This recommendation goes beyond revenue sharing to reach individuals.

Tax credit for persons past 65 with incomes under $15,000 would be allowed for the amount of real property taxes they pay in excess of 5 percent of household income up to a maximum $500 total tax credit. For this purpose, 15 percent of *rent* paid would be considered as real property taxes. The plan would thus give tax relief to both older homeowners and those who rent.

The seriousness of the property tax problem facing many older Americans is developed in some detail elsewhere in this report. It is one product of the inflationary spiral over which a property owner can effect least control. These excessive burdens call for early action by the Congress, the Administration, and State and local governments.

The general Revenue Sharing program, proposed by the President, has already been enacted and implemented so as to strengthen State and local governments. This measure plus the pending special Revenue Sharing programs are designed to diversify revenue sources for State and local governments, thus reducing their dependence on the property tax. As a result some governmental units already have been able to reduce property tax rates while others have avoided increases.

We recommend development of transportation services with particular reference to special needs of older persons.

While not quite as obvious as needs of basic income, health care, or housing, the transportation needs of older persons have a direct relationship to their ability to live full and rewarding lives.

In hearings by the Special Committee on Aging and meetings related to the White House Conference on Aging, as well as other

sources of information about needs of older persons, it has become evident that one of the most serious problems faced by many elderly is getting from one place to another as part of their daily lives.

The elderly transportation problem is not confined to the cities, where rising public transportation fares and elimination of old neighborhoods are making it increasingly difficult for older persons to make necessary trips from their places of residence—to stores for marketing, to doctor's offices for health services, or on visits to friends and relatives—as part of their need for social intercourse. The problem is also serious for many in small towns and rural communities which now have high percentages of persons past 65 among their populations.

Without good transportation, the problems of isolation and loneliness, twin spectors of advanced age, become realities for many older persons. Added to problems of procuring necessities of life resulting from transportation difficulties, loneliness and isolation can easily increase jeopardy to health an individual faces during later years.

That the transportation problem is massive and complex cannot be questioned. It is doubtful if there are any magic answers readily at hand. But the serious need for adequate transportation arrangements demands full attention from our technological, social and economic resources if the highest level of life quality is to become a reality for older America as a whole.

We recommend development of effective Federal responses to the need for in-depth economic, social, physiological, and psychological research in aging on a permanent basis, including appropriate mechanisms to assure that new knowledge about the aging process and mental, physical and socio-economic problems of older persons in a changing society promptly reaches professionals and others engaged in services on behalf of older persons, and that newly acquired knowledge be available for use in developing more effective national policies in aging.

That older persons themselves recognize the need for research as a major tool in long-range responses to problems in aging is manifest by support given to voluntary efforts, such as the Ethel Percy Andrus Gerontological Center at the University of Southern California, which was sponsored by the National Retired Teachers Association and the American Association of Retired Persons.

Such efforts are to be commended highly, but it is apparent from the gerontological research centers now in operation that the magnitude of the task requires effective participation and funding by the Federal Government. The potential for improved quality of life among older Americans which is offered by well conceived and adequately funded research is important.

In re-stating this recommendation from previous reports, we are sensitive to the fact that the benefits of all kinds of research inure to older persons. Obviously major medical research is a case in point, including that directed at causes of and cures of such important diseases as cancer, osteomyelitis, cardiovascular problems, arthritis, rheumatism and others which take a substantial toll each year in life and comfort among our older people. Even atomic research creates potentials for progress in aging. In the final analysis social and economic research may be of comparable importance.

We are fully aware that hundreds of millions of dollars are currently being spent by the Federal Government in research of benefit to older America. We recognize that, as in all things, there are limits to effec-

tive application of money to the problems with which research is concerned. We believe, however, that within the limits of skilled research personnel available to this Nation, more should be done in this field. If not more expensively, at least more effectively.

There appears to be a crying need, in the midst of our already wide-spread research effort, that there be a coordinating mechanism which can assure that the benefits to older persons of such research reach down to them in the communities where they live. So far we have not yet achieved this important objective.

MAJOR 1972 OMISSIONS: RETIREMENT INCOME TAX CREDIT AND VETERANS PENSIONS

While Congress was enacting extensive improvements in Social Security, Railroad Retirement and other income programs during 1972, there were two major omissions which deserve action.

The first was failure to update the retirement income tax credit provisions of the Internal Revenue Code.

The second was failure to amend the veterans pension program so that eligible veterans receive full benefit from the Social Security increases enacted during the year.

Other omissions also created new inequities, but these two are most serious. It is hoped that one of the others, failure to assure Old-Age Assistance recipients of full participation in Social Security increases, will be resolved in January with full implementation of the new Supplemental Security Income program, including State support.

We recommend that retirement income tax credit provisions of the Internal Revenue Code be amended so as to provide fully equitable income tax treatment of retirees regardless of whether they receive Social Security or Railroad Retirement benefits or not.

Continued failure to act on this matter of tax equity will exacerbate a tax injustice imposed on retirees who have little or no Social Security, which has already lasted far too long. Among the victims of such discrimination are many retired school teachers, firemen, policemen and other public servants not under Social Security.

The purpose of the retirement income tax credit has been to provide equitable tax treatment for persons not on Social Security or Railroad Retirement or similar sources of *tax-exempt* pension income, by giving such persons comparable consideration for income tax purposes.

Unchanged since 1954, the basic level of income eligible for the tax credit is now $1,542. We have long advocated liberalization of this credit provision so as to re-establish equity which recognizes increases in tax-exempt retirement income generally available through programs such as Social Security and the Railroad Retirement system.

We believe the Congress should exercise continuing review of the retirement income tax credit to maintain its equity with any and all increases in Social Security.

Both the Senate and the House of Representatives approved updating the retirement income tax credit, albeit with some differences in language, as part of their respective actions on the Social Security Amendments of 1972, but it was dropped in conference, presumably because of differences between the two versions.

In view of last year's endorsement by both chambers of Congress, we believe further delay in action on this proposal is inexcusable.

We recommend that veterans pension legislation be amended by increasing the income limitation used in determining eligibility and in other appropriate ways so that participants in the pension program receive the benefit of recent Social Security entitlement increases.

Approximately 76 percent of the 2,366,000 persons qualifying for pensions under the Veterans' Administration program during 1972 derived part of their income from Social Security payments.

None of these persons received the full benefit of Social Security increases approved during 1972. There were 25,000 who became ineligible for *any* Veterans' Administration pension, 20 percent of whom suffered aggregate *loss* in income.

For the remainder, veterans pension payment reductions ranged from $3 to $11 a month, with an average reduction of $7. None of the latter suffered aggregate losses in total income, but reductions in their pension benefits were balanced against the Social Security increases to which they became entitled.

Last year the Senate acted favorably on legislation to modify eligibility standards and payment levels for veterans pensions in an effort to assure that participants receive full benefit of their higher Social Security entitlements. There was not enough time for action on the Senate bill by the House of Representatives. We believe prompt action should be taken by both the Senate and the House.

BETTER COMMUNITIES ACT

Reference is made at the beginning of Chapter V of the majority report to "Administration plans to terminate seven categorical Community Development programs this year." Except for a brief paragraph which ignores positive implications of the President's proposed new Better Communities Act, the chapter contains no discussion of Administration alternatives.

To clarify the record, the following is quoted from March 20 testimony by Housing and Urban Development Secretary James T. Lynn before the House Committee on Banking and Currency.

Secretary Lynn said:

> Under the Better Communities Act, many current categorical programs would be replaced, allowing local government to make decisions on the most effective use of the funds. The $2.3 billion funding, to begin July 1, 1974, actually exceeds the amount appropriated this fiscal year for the programs to be replaced. We do not foresee substantial problems arising nationally during the transition from the present time to the start of the Better Communities Act in July 1974. We say this for the following reasons:
>
> • First, the rate of activity at the local level for the existing categorical programs being replaced will continue at a level at least equal to the experience of the past several years. This is reflected in terms of actual outlays for these programs—$1.85 billion in fiscal year 1973 and $1.90 billion in 1974. We expect, for example, that 140 neighborhood facilities will open their doors for service in fiscal year 1974 as compared to 120 in fiscal year 1973. Open space expenditures will increase from $57 million in fiscal year 1973 to $70 million in fiscal year 1974. Two hundred water and

sewer projects will be started in each of fiscal years 1973 and 1974. As of June 30, 1973, the total unspent money in community development categorical programs already obligated to communities will be about $7.4 billion—an amount sufficient to fund programs at current levels well past—in some cases several years past—fiscal year 1974.

• Second, in the case of the ongoing community development programs, primarily Model Cities and Urban Renewal, most of the funding for these programs will, following historical patterns, take place in the last three months of this fiscal year. For example, in Urban Renewal a total of $1.2 billion remains to be obligated along with about one-half billion dollars for Model Cities. Therefore, most cities will enter fiscal year 1974, starting July 1, 1973, with recently approved grant programs which should provide them with funding adequate to permit activities to be carried out until the beginning of special revenue sharing under the Better Communities Act.

•Third, unlike the existing categorical programs being replaced, communities will be able to commence their program activity beginning July 1, 1974, under the Better Communities Act, without the necessity of the traditional long delays caused by Federal applications and review.

Many of the complaints coming from communities involved in Urban Renewal and Model Cities are completely unrelated to the program terminations. They have arisen, instead, because of HUD management efforts to tighten the administration of these programs. In the Model Cities program, for example, a small number of cities are taking a substantial cut in operating level because of their poor track record to date . . . This winnowing out process would have taken place regardless of the shift from categorical grant programs to revenue sharing.

SOCIAL SECURITY IN THE FUTURE

The Special Committee on Aging this year has begun a series of most important hearings on "Future Directions in Social Security." Hearings held so far, with a distinguished list of experts in the field, are reported in Part One of this report. Their discussions of major issues have been most valuable.

It is to be assumed that, before the series is completed, the Committee on Aging will have received testimony from many more witnesses and that there will be a full exposure of differing points of view regarding various aspects of Social Security including benefits, financing methods, and inter-relationships of Social Security to other programs aimed at meeting economic needs of older Americans.

While the testimony so gathered will be of great help in long-term evaluations of Social Security's future role in a constantly changing society, it is obvious that there are many improvements in the system concerning which ample evidence is already available. Among them are two, not referred to earlier in this statement, which we recommended in last year's minority report on which action has not yet been taken. It appears appropriate to reiterate them at this point.

We recommend upward adjustments, actuarily determined, in Social Security benefits for those who defer retirement beyond age 65, so that their continuation in the work force will not be penalized.

In the Social Security Amendments of 1972, recognition was given to the principle that those who defer retirement should receive higher payments. As a result, the law now provides for benefit increases of 1 percent for each year of deferral.

We welcome this as a precedent, but it still falls far short of equitable treatment of those who work past 65.

While the number of persons in the full-time work force who are over 65 years of age has been diminishing in recent years, the fact remains that loss of Social Security benefits to them often imposes a severe penalty for their continuing contribution to the Nation's wealth. It may be argued, indeed, that such penalties may have been a factor in increasingly premature retirement patterns in this country.

In our judgment the Social Security system should provide reasonable flexibility so that payments from it may be tailored to the widely different retirement needs and desires of individual beneficiaries. We now have such flexibility through provisions which permit retirement before 65 with actuarily determined reductions in benefit entitlement. Justice and sound national policy in aging suggests that equal flexibility should be offered those who want to defer retirement.

In a sense, this proposal is a companion measure to our recommendation which appears earlier in this statement for liberalization or elimination of the earnings test penalties against those who choose to work. That both of these relate to our other recommendation for expansion of job opportunities for older Americans is apparent.

In a nation where need for increased abundance continues to grow, despite our comparative wealth, the loss of skills, wisdom and productive capabilities of older persons who want to continue in active work roles, complete or limited, appears totally unjustifiable. Presidents Eisenhower, Kennedy, Johnson, and Nixon have all voiced similar views. We believe it is time for the nation to respond. In this we are certain that we reflect the view of most older Americans.

We recommend upward adjustments in Social Security benefits for married couples both of whom work and thus pay dual Social Security taxes without receiving comparably higher payments when they become OASDI beneficiaries.

This proposal, which we regard as simple equity in keeping with the wage-related principles on which Social Security is based, was discussed at some length in previous minority reports and also in Part One of this year's committee report.

As the practice of working wives has become increasingly common since World War II, it appears only fair to take account of the contributions to Social Security thus made by couples and to reflect them in the benefit schedules.

The House of Representatives passed a proposal aimed at correcting this inequity as part of the Social Security Amendments of 1972, but it was dropped in the Senate version of the bill. We believe it should receive prompt attention during the present session of Congress.

BI-PARTISAN INDEPENDENT SOCIAL SECURITY COMMISSION

We recommend that the Congress enact legislation to create a permanent, independent, bi-partisan commission to maintain constant surveillance of Social Security, to provide opportunity for hearing all shades of expert opinion, and to provide the President, the Congress and the people with sufficient information to give maximum assurance that all decisions related to Social Security are well taken. Such a commission should have responsibility also for constant overview as to the Social Security system's adequacy and performance in meeting needs of the country and might well include a mechanism for adjustment of grievances against the system.

The above recommendation, which we first offered and discussed at length as part of last year's Special Committee on Aging report, continues, in our judgment, to deserve high priority.

One way of implementing this would be through enactment of S.J. Res. 48, a Joint Resolution to establish a National Commission on Social Security, introduced early in the current session of Congress by Senators Hiram L. Fong and Paul J. Fannin.

Senator Fong's statement at the time of introduction of the Fong-Fannin Resolution reflects our view with regard to what can be an important piece of legislation on behalf of older Americans.

Senator Fong said:

> The National Social Security Commission would be charged with continuous review of Social Security's effectiveness. Included in such review would be:
>
> 1. Imaginative consideration of innovations which may strengthen the system's ability to help provide decent economic and health security for its beneficiaries without excessive tax burdens on wage-earners and their employers;
> 2. Persistent analysis of inequities within the system which may affect substantial numbers of its participants;
> 3. Positive assurances of the system's fiscal integrity and its ability always to meet its obligations, and
> 4. Careful determination of the system's possible effects, positive or negative, on other elements in our society, both private and public, through which Americans strive for economic well-being.
>
> We give full recognition to the long record of excellent administration of Social Security by the Department of Health, Education and Welfare. No less important has been the distinguished work of the Senate Committee on Finance and the House Committee on Ways and Means. In no way would the independent National Social Security Commission diminish or derogate their responsibilities. On the contrary it would be a new and valuable source of help to them.
>
> Under S.J. Res. 48, the National Social Security Commission will have a continuing responsibility to study, in-

vestigate and review the Federal Old-Age, Survivors, and Disability Insurance program and the Health Insurance programs which operate under authority of the Social Security Act.

At present the Social Security Act provides for such an overview by the Advisory Council on Social Security, but only on an intermittent basis.

To rely for such important studies on an Advisory Council, which holds a limited number of meetings during one year out of four, as is now the case, is unfair to the American people, the Congress and the President. The almost inevitable dependence on the Social Security program's administrative agency by such a part-time panel, no matter how distinguished its membership, also leaves much to be desired.

Social Security is too important, too big to be the object of part-time review.

The importance of the Commission's work, as set forth in the resolution, is underscored by the manner of appointment of its nine members and the provision that the Commission shall be bi-partisan.

The Commission Chairman and four members will be appointed, on a bi-partisan basis, by the President with the advice and consent of the Senate. Two members each, no more than one from a single political party, will be appointed by the President Pro Tem of the Senate and the Speaker of the House.

Pertinent to our purposes in introducing S.J. Res. 48 are hearings currently in progress by the Senate Special Committee on Aging under chairmanship of the distinguished senior Senator from Idaho, Frank Church. The subject of these hearings is "Future Directions in Social Security."

I anticipate that when this series of important hearings has been completed, we will have a valuable base on which the National Social Security Commission can build.

HIRAM L. FONG,
CLIFFORD P. HANSEN,
EDWARD J. GURNEY,
WILLIAM B. SAXBE,
EDWARD W. BROOKE,
CHARLES H. PERCY,
ROBERT T. STAFFORD,
J. GLENN BEALL, JR.,
PETE V. DOMENICI.

APPENDIXES

Appendix 1

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. ACTION

FEBRUARY 20, 1973.

DEAR SENATOR CHURCH: In response to your request of December 15, 1972, I am enclosing a report summarizing ACTION's activities for Older Americans.

Please let me know if additional information is needed on any of our Volunteer programs.

With best wishes.

Sincerely,

ERIC C. SILBERSTEIN,
Assistant Director of ACTION, Congressional Affairs.

[Enclosure]

ACTION/VISTA

The Older American VISTA Volunteer brings a unique insight and experience to VISTA's efforts to assist local communities to alleviate the conditions of poverty. Older Americans currently comprise 10% of VISTA's Volunteer strength, numbering 430 people as of February 1973. They are serving 153 different projects across the country. All of the above figures represent an increase over last year, bringing the overall total of older Americans who have served in VISTA since its inception to 3,486.

VISTA actively seeks the skills and experience of older Volunteers for a variety of challenging assignments. In Arizona, for instance, 56-year-old Julie Baird developed a Basic Adult Education program for prisoners of the county jail. Now the county has institutionalized the education program, Ms. Baird has moved to another area where she is assisting in the establishment of education curriculum for adults in 19 small Pueblo towns in New Mexico.

A recently developed project utilizes Older Americans from bi-lingual ethnic backgrounds as VISTA Volunteers to help other ethnic senior citizens. In Project Senior Ethnic FIND currently operating in Chicago, Illinois, Detroit, Michigan, Gary, Indiana, and Cleveland, Ohio, these Volunteers, who are recruited and work in their own communities, seek out and assist local persons who are eligible for benefits which they are not receiving often due to language and cultural barriers.

These are but a few examples of the projects throughout the country, where older Americans are making valuable contributions to the efforts of VISTA in order to help poor communities to help themselves. Additional information and applications to become a VISTA Volunteer are available from ACTION, Washington, D.C. 20525.

INTERNATIONAL OPERATIONS

Peace Corps programs are not designed to have specific impact on the problems of the aged in America, but the Peace Corps does offer a challenging and rewarding opportunity for Volunteer service abroad to older Americans with special skills. Approximately 5% of all Volunteers (312) are fifty years of age or

older, of whom 134 are above the age of sixty. They are serving as teachers, health workers, librarians, farm advisers, and skilled craftsmen. The skills and knowledge they have acquired through a lifetime of experience are being put to work on key social and economic development problems of host countries where the Peace Corps works. Service in the Peace Corps permits these older Americans new and exciting careers of service.

Service Corps of Retired Executives (SCORE)

Service Corps of Retired Executives is a Volunteer group of men and women who have successfully completed their own active business careers and now offer their expertise and services to assist small and minority businesses and community organizations with management problems. Since SCORE began in 1965, it has served more than 175,000 businessmen and women. Business concerns requiring help frequently are referred to SCORE chapters, numbering over 700 as of February 1973, by the Small Business Administration.

Approximately 5,000 Volunteers are working in 49 states, the District of Columbia, and Puerto Rico. To qualify as a SCORE Volunteer, an individual must be a retired businessman or woman who is willing to spend time and energy helping small businesses. Volunteers in this Program work free, but are reimbursed for some out-of-pocket expenses.

SCORE Volunteers serve in their home communities or in nearby communities. They have helped realtors, retailers, janitor and supply shops, funeral homes, grocery stores, hand laundries, shoe repair shops, dry cleaners, auto body shops, truckers, clothiers, and a wide variety of small manufacturers. There are few forms of private enterprise that have not received their assistance. SCORE chapter meetings provide guidance in keeping Volunteers informed on Federal, State, and local resources which may benefit small businesses. Additional information can be obtained by writing ACTION/SCORE, Washington, D.C. 20525.

The Foster Grandparent Program (FGP)

The Foster Grandparent Program is authorized under Title VI, Part B of the Older Americans Act of 1965, as amended. Originally developed as a cooperative effort between the Office of Economic Opportunity and the Department of Health, Education, and Welfare (Administration on Aging), the Foster Grandparent Program began with 21 local projects. The Program was transferred to ACTION in July 1971, in accordance with Executive Reorganization Plan No. 1.

The purpose of the Foster Grandparent Program is to provide Volunteer opportunities for low-income persons, aged sixty and over, to render supportive person-to-person services in health, education, welfare, and related settings to children having special needs. Thus, the Program meets the needs of two groups: the elderly poor and children with physical, mental, social, or emotional health needs who are deprived of daily parental relationships. The Foster Grandparent Program is the major Volunteer Program through which older persons can improve their economic condition by engaging in meaningful and productive activities. One of the primary objectives of the Foster Grandparent Program is to provide older persons with satisfying community service roles through which they can maintain a sense of personal growth and self-worth, enrich social contacts, retain physical and mental alertness; and, at the same time, provide to children with special needs the love, warmth, and attention that is essential to their growth and development.

Initially, the Foster Grandparent Program explored 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 was expanded to serve children in a wider range of settings including correctional institutions; hospitals; mental health clinics; juvenile homes; and institutions for mentally retarded, physically handicapped, and dependent and neglected children.

The Foster Grandparents serve a total of four hours a day, five days a week and receive a small stipend for their service. In addition, the Foster Grandparents are reimbursed for, or provided with, transportation and, where possible, are provided a nutritious meal daily. They are covered by accident insurance and each Foster Grandparent receives an annual physical examination. An extensive orientation program is provided; and through the professional staff of each program, Foster Grandparents receive counseling on personal matters and information regarding benefits available through Social Security, Medicare, legal services, and other community, State, and Federal programs.

In Fiscal Year 1972, with an appropriation of $25 million, the Foster Grandparent Program experienced dynamic growth. During this period the Program expanded from 67 local projects with 4,400 Foster Grandparents serving in 200 institutions to 135 projects in 50 states, Puerto Rico and the District of Columbia. Approximately 10,400 Foster Grandparents serve 20,800 children each day in over 400 child care settings. ACTION will maintain this level of FGP activity in Fiscal Year 1973.

In 1972, the Booz, Allen Public Administration Services completed a cost-benefit study of the Foster Grandparent Program. The study revealed that the Foster Grandparents and the children they serve, as well as the host institutions and society at large, benefit from the Program. Benefits to Foster Grandparents include improved health, greater independence, decreased isolation, and fewer financial problems. Benefits to children occur in the areas of physical, social, and psychological development. Institutions derive savings in staff time and savings due to early release of some children served by Foster Grandparents. Society, at large, benefits from the cancellation or reduction of public assistance payments, increased payments to the Social Security trust fund, and increased tax revenues from Foster Grandparents stipends.

The Booz, Allen results show "that in terms of pure economic benefits and costs, total benefits of the FGP exceed its costs." Based on a Federal cost of $10.2 million, "a conservative estimate places the net excess of economic benefits over quantifiable economic costs at $1,650,000. More importantly, the Foster Grandparent Program offers to older persons an opportunity to serve their communities and themselves, to live with the increased self-esteen, independence and sociability that is vital to the enjoyment of later years.

In many instances the Foster Grandparent Program offers to the children served an opportunity to participate more fully in the activities and joys of life. For example:

Michael was in a State school for the mentally retarded. One Christmas, following a visit to his home, Michael returned to school with his fists permanently clenched. His fingers could not be pried apart; he was completely non-communicative and the medical staff of the school was at a loss as to how to help him. Finally he was assigned a Foster Grandparent, a retired father, who did what no doctor had been able to do: with infinite patience and love, he got Michael to unclench first one fist and then the other, and finally to hold his hands.

Another typical case is Laurie. She was one of several children dropped from "learning" programs due to lack of ability. Her Foster Grandparent brought Old Maid cards . . . . In three days, with encouragement, the child who "couldn't learn" would squint at each card, bringing it a few inches from her eyes, grimace, then place it on top of the matching card. She is learning colors, numbers, words, and most of all, "to belong."

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 persons with an improved standard of living, but has demonstrated that older persons have the talent, skill, experience, and desire to serve their communities by meeting some of the unmet human needs of our society.

This desire to serve was expressed repeatedly by older persons at the 1971 White House Conference on Aging. While most retired older persons are not interested in employment or new job opportunities, many still have a need to remain active, useful, and productive in the later years. The Conference Section of Retirement Roles and Activities established this need as a national priority.

During 1973, ACTION, through the Older Americans Volunteer Programs, will continue to develop meaningful Volunteer opportunities for persons 60 years of age and over. Additional information can be obtained by writing ACTION/Foster Grandparent Program, Washington, D.C. 20525.

The Retired Senior Volunteer Program (RSVP)

The Retired Senior Volunteer Program was authorized by the Older Americans Act Amendments of 1969. An appropriation of $500,000 was made at the beginning of 1971, permitting the Administration on Aging to issue Rules and Regulations and to fund eleven programs before July of 1971. A study of senior Volunteer programs, contracted for by the Administration on Aging with a private consulting firm, was completed in June, 1971. Their report, "Recommendations for Developing RSVP, the Retired Senior Volunteer Program", may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, for $3.00, by reference to Stock Number 5600–0001.

On July 1, in accord with Executive Reorganization Plan No. 1 of 1971, the Retired Senior Volunteer Program was transferred to ACTION. In August an appropriation of $5 million was made for the Program for Fiscal Year 1972. This appropriation was increased to $15 million late in December 1971.

Nationally, the purpose of the Retired Senior Volunteer Program is to develop a recognized role in the community and a meaningful life in retirement for older adults through significant Volunteer service. Retirement from work activities, combined with separation from family and loss of friends and established relationships, often deprive older people of contacts and resources that might permit them to engage in meaningful activities. Many persons of retirement age need help to find personally satisfying opportunities to be usefully involved in community life, to contribute a full measure of their talents, abilities, and experience. The focal point of RSVP activity is the needs and interests of the Senior Volunteer.

ACTION grants are awarded to support the development and operation of local programs providing community Volunteer opportunities for persons 60 years of age and over, and to provide round-trip transportation between the homes of Senior Volunteers and their Volunteer stations or, as needed, assistance with the costs thereof. Meals are available without cost to Senior Volunteers at many Volunteer stations. Accident insurance is provided for all RSVP Volunteers.

A Retired Senior Volunteer Program is inherently a local Program. It is locally planned, operated, controlled, and supported. During the project period, which can be as many as five years, an RSVP operates with Federal financial and technical assistance under ACTION guidelines, rules, and regulations. Federal funding is provided on an annually decreasing basis with the goal being full support of the Program with non-federal funds in five years. This is explained fully in the RSVP Program Information Statement available from ACTION, Washington, D.C. 20525.

Local Retired Senior Volunteer Programs encourage organizations and agencies to develop a wide variety of Volunteer opportunities for retired persons. Volunteer opportunities are arranged to match the interests, abilities, and physical capacities of older persons who wish to become Volunteers through RSVP. Older adults are actively encouraged to contribute their time, experience, and skills in service to their communities. There are no income, education, or experience requirements for a retired person to become a Senior Volunteer.

Specific assignments arranged for Senior Volunteers offer varied types of opportunities for them to serve people of any age. Assignments are made to publicly owned and operated facilities or projects and to local programs sponsored by private, nonprofit organizations. Examples are schools, courts, libraries, museums, hospitals, nursing homes, day care centers, institutions, and programs for shut-ins. Volunteers under RSVP may not be assigned to activities involving the construction, operation, or maintenance of any part of a facility used or to be used for sectarian instruction or as a place for religious worship. RSVP Volunteers cannot displace employed workers or impair existing contracts for service.

Applications for grant assistance to operate a Retired Senior Volunteer Program may be made by local public agencies and nonprofit private organizations. Highest priority is given to those applicants which possess the greater number of the following characteristics:

Well established and having a commitment to the needs and interests of all older adults in the community without regard to income, education, and experience.

Multi-purpose organization having a broad focus of involvement with community problems.

Good working relationships with a wide variety of community organizations and agencies.

Recognized capacity to operate direct community service programs.

Experience in developing Volunteer service opportunities.

Strong base of local financial support and the capacity to develop additional sources of local funding.

Reputation in the community that appeals to or attracts people of retirement age.

At the end of 1972, nearly 300 communities had been granted Federal assistance to establish a Retired Senior Volunteer Program, and more than 8,500 senior Volunteers were serving their communities at least once a week and enriching their own lives. It was anticipated that by July, 1973, the number of local programs would increase to between 500 and 600. The number of senior Volunteers

would at the same time increase to at least 40,000, with a potential increase a year later of close to twice that number. For additional information write ACTION/RSVP, Washington, D.C. 20525.

ITEM 2. ADMINISTRATION ON AGING

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., April 16, 1973.

DEAR MR. CHAIRMAN: Enclosed is the report from the Administration on Aging and the Social and Rehabilitation Service* which you have requested for the annual report of your committee. We hope that you will find this information helpful.

Sincerely,

STANLEY B. THOMAS, Jr.,
Acting Assistant Secretary for Human Development.

[Enclosure]

THE ADMINISTRATION ON AGING—1972

During 1972, the Administration on Aging carried out, on many different fronts, a variety of activities on behalf of older Americans.

A. STATE AND COMMUNITY PROGRAMS

During 1972, funds were provided for three 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 planning, services, and training programs on behalf of the elderly.
3. Areawide Model Project program.

The first two programs, above, are formula grant programs administered by designated State agencies on aging, while the third is a program of discretionary grants to State agencies on aging.

In addition, a new national Nutrition Program for the Elderly was enacted into law in March 1972 as Title VII of the Older Americans Act. This program will also provide formula grants to States to be administered by designated State Agencies on Aging. No funds have yet been provided for implementation of the Nutrition Program.

The State and Community Programs are discussed in greater detail below.

1. STATE PLANNING

Authorization for appropriations for Titles III, State and local programs for the aging, expired on June 30, 1972. AoA developed a legislative proposal for a new authorization for Title III appropriations and a major revision of the Title III program.

The proposed new Title III program was introduced on March 20, 1972 as H.R. 13925 and S. 3391. Its major features were as follows:

(1) Specific goals for Title III;
(2) Division of each State into planning and service areas;
(3) Selection of priority planning and service areas for the establishment of an Area Agency on Aging and development by that Area Agency, with the public and private service providers, of an area plan to create a network of comprehensive and coordinated services;
(4) An annual State—Operating plan;
(5) Concentration of funds into the priority areas;
(6) Implementation of State and area plans by—
  (a) persuasion of the public and private service providers to expand their commitment to services for the elderly from their own budgets (the "draw down" of other resources),
  (b) persuasion of the public and private service agencies to link their services so that multi-problem older persons do not get only "the speciality of the house" when they go to a particular service agency, and

*See Item 19, p. 234.

(c) 90 percent incentive (or "front-end") funding of all or part of an expansion, improvement or start-up of services which the provider agency cannot immediately fund, in order to allow the provider time to absorb the budget increase;

(7) Evaluation of program and problems in implementing the plan in order to improve it.

The bill which was eventually passed by the Congress, H.R. 15657, adopted most of the AoA proposal for Title III. However, it was disapproved by the President because it also included categorical provisions that he believed would duplicate existing services and discourage close coordination and cooperation of community agencies and resources, and because it authorized expenditures far above what could be used effectively and responsibly. New legislation (S. 50 and H.R. 71) has been introduced in the 93d Congress.

A special meeting of State Executives on Aging was held in Washington, D.C. in February. The meeting was called to present and discuss the strategy proposed by the Administration on Aging for expanded State and community programs of the Older Americans Act as provided in the proposed legislative provisions of H.R. 13925. The purpose of this meeting was to provide guidance to the State agencies on the activities which they should plan to undertake in preparation for this strategy. An AoA paper on the strategy for FY 1973 and beyond was shared with the State agencies at this meeting to assure their understanding of the new opportunities for programs for the elderly. It was recommended that preliminary contacts be made with the governors' offices concerning the selection of planning and service areas, as well as contact with other State and local people who would be involved in the planning, coordinating and implementing at a later date.

A five day training program on planning, under a Title V Older Americans Act grant, was conducted for State agencies on aging personnel in April and convened in Philadelphia and in San Francisco. The training course was developed and presented by the University of Pennsylvania School of Social Medicine under the direction of Elias Cohen, Assistant Professor in the School, and former Commissioner on Aging for the State of Pennsylvania. The training was based on the comprehensive planning aspects of the strategy for an expanded Title III program. A Title V grant was also made to the University of Michigan for development of a guidebook on area planning, and related training programs.

In March, S. 1163 was enacted into law as Title VII—Nutrition Programs for the Elderly. This legislation provided a major development in programs for the elderly under the Older Americans Act. It authorized $100,000,000 for FY 1973 and $150,000,000 for FY 1974 to provide nutrition and related social services to elderly Americans. The program was designed to foster socialization as well as sound nutrition. The implementation of a social program of this magnitude required extensive preliminary planning activities at the AoA and State level. AoA's Office of State and Community Programs developed the Federal Regulations and State Plan amendment guidance necessary to enable the States to implement the Program. In addition, the Office developed a "how-to" handbook to guide local communities in effective operation of nutrition Projects. AoA also provided the State agencies with special training and technical assistance, through contracts with private firms and organizations, designed to meet their requirements for planning assistance in implementing the new nutrition program.

2. COMMUNITY PROGRAM ACTIVITIES

During 1972, approximately 1,000,000 older persons were served by approximately 1,500 expanded community projects under Title III of the Older Americans Act of 1965 as amended. Title III grants are awarded by State Agencies to local public or private non-profit agencies to strengthen existing, and to develop new, community services for the elderly and to stimulate community interest to meet identified needs of the elderly.

In Home and Out-of-Home Services were developed and implemented to increase the capability of the elderly to maintain independent living and to prevent unnecessary institutionalization. Many elderly shut-ins were reached through this effort. These in-home and out-of-home services made it possible for elderly persons to maintain a sense of dignity and independence in their own communities. In-home services are homemaker services, home health aides, escort service, friendly visiting, chore service, telephone reassurance, home repair and delivered meals. Transportation is a major component of any service aimed at maintaining independent living, as it frequently means the difference between remaining at home or possible institutionalization. Some services such as complete medical

services, cannot be brought to the home. Point-to-point transportation on a request or as needed basis makes it possible for the elderly person to receive necessary care and then return home.

Transportation to solve mobility problems among the elderly continued to receive emphasis in 1972. More than half of the community programs provided transportation as a component or as the sole service. Many of these programs had buses, or mini-buses which were radio-equipped; cars and other vehicles were also used. Transportation geared especially to the elderly enabled them to keep medical appointments, to visit senior centers, to participate in congregate meals, to go to grocery stores, to churches and other places for social contact and to information centers for counseling and guidance.

Health related services also helped older persons to continue to maintain independent living. Home visits by nurses under the direction of a physician, and by home-health aides under the supervision of a registered nurse, provided nursing and personal care as well as light housekeeping. Other out-of-home health services were health education, geriatric screening and referral, and immunization programs. A number of programs gave particular attention to handicapped older persons, such as the blind or deaf.

Meals provided in either congregate or home-delivered settings can mean the difference in maintaining independent living. While funding was not available during 1972 to begin providing this service under the new Title VII program, it was provided in some communities under the older, more established Title III program of community services. At congregate meal sites, other services offered were nutrition education, recreation/leisure time activities, information referral, counseling and transportation. Many elderly persons paid a minimal cost for meals, based on their ability to pay.

Volunteers, many of whom are elderly themselves, assisted in providing such services as friendly visiting, telephone reassurance, teaching adult education courses to other older persons and in the preparation and delivery of meals. Many were also involved in the planning of community activities and services for the elderly.

Under Title III, State agencies provided support for senior centers which were located in housing projects, churches, other public and private buildings and some institutions. Some of these senior centers established satellite centers located in neighborhoods where the elderly reside. These decentralized centers provided and delivered services tailored to the particular needs of the elderly living in the area.

Other community programs offered courses in arts and crafts, provided adult education and training, employment, and information and referral to enable the older person to find and maintain post-retirement employment. Opportunities for participation and active engagement in community life were the results of many community programs.

Forty-three percent of the community programs were located in rural areas; 57 percent in urban areas; and 14 percent of the urban area programs were located in Model Cities Areas. 81 percent of the community programs served the needs of the low-income elderly.

3. AREAWIDE MODEL PROJECT PROGRAM

The Areawide Model Project Program was originally authorized by the 1969 Amendments to the Older Americans Act. This program provides for discretionary grants to State Agencies on Aging for the conduct of Areawide Model Projects in selected geographic areas. State Agencies receiving awards may operate such projects directly or through contractual arrangements with designated local agencies.

The Areawide Model Project Program seeks to develop and test innovative approaches to change those conditions that prevent or limit opportunities for older persons to live independently and participate meaningfully in community life. Each Areawide Model Project must propose realistic plans for meeting a stated objective determined by a high priority need in the community. Initially, a project undertakes those activities necessary to identify or clarify a pressing need of its elderly citizens in a selected geographic area having potential for solution within the scope of this program. Secondly, a plan of action must be developed which describes in detail the proposed scheme to combat in a comprehensive manner the need that has been identified. If approved, the project undertakes those steps necessary to implement the plan in an efficient manner throughout the project area.

The objective of the planning phase and implementation of the plan of action is to integrate all existing services and to establish new ones, where necessary, to meet the identified needs of older persons. Each Areawide Model Project has a target population which includes a high percentage of low income and minority group elderly. Each has an Area Task Force, the members of which include older persons and representatives of major public and private agencies with programs for the elderly. The Task Force participates in both planning and implementing projects.

The Areawide Model Project Program was first implemented in June 1971. At present, there are 21 Areawide Model Projects in operation.

The Areawide Model Projects have been operating a variety of service delivery systems to meet the needs each identified as a priority. Several components are common in all the projects, such as an information and referral component and provision of those services identified as necessary to prevent institutionalization and to maintain independent living. A major goal of the Areawide Model Program is to locate the Areawide Projects in a variety of settings and situations in order to develop models for training and demonstration. These models can then develop the tools for other communities to use for solutions and approaches to similar problems faced by their elderly citizens.

Information and Referral Services are an important means to assure access to services provided. Older people can find answers to problems. when in need. The Information and Referral service is a vital link between the isolated elderly and community services designed to meet their needs. Information services enable the community to identify and reach isolated persons through the use of outreach workers. Service gaps can be the basis for community planning to meet needs. The information service is the central referral source through which older persons are identified as needing services in their own homes or in a central facility.

Outreach services are active efforts on the part of the project staff to seek out and identify elderly who are in need of social, health, nutritional and protective services—both in-home and out-of-home. Volunteers are often trained as outreach workers.

Consumer education and consumer protection are important aspects of helping the elderly maintain independent living. Legal help is often required in writing wills, protecting legal rights, preventing the elderly from being swindled by unscrupulous people, sale of property, location of relatives and clarification of eligibility for pensions or other benefits.

Home help services are those services which assist older people with tasks they can no longer do for themselves. Examples of these are: the household handyman to do household repairs and perform seasonal tasks, such as changing screens, cleaning yards or repairing porches and stairs. In-Home services include Homemaker Service which provides home management, home maintenance and personal care. Chore Services may be employed to help with shopping, simple household repairs, lawn care and snow removal, when the elderly individual does not require a trained homemaker. Home health aids provide personal care under the supervision of a registered nurse when the services of a homemaker are not needed to maintain independent living.

Transportation services support the mobility of elderly individuals, and are designed to make it possible for them to visit churches, senior centers, physicians, clinics and relatives. Arrangement for a special bus is indicated when public transportation is inaccessible or not available.

A variety of Health services may be offered. Health screening is a method of case-finding of unrecognized disease or defects by tests, examinations or other procedures which can be administered rapidly to groups of persons. Health services are provided in physicians' offices and in geriatric clinics as well.

Counselling services are directed toward enabling the older person to recognize, understand and find solutions to problems related to his health and welfare through utilization of community resources.

Food and nutrition programs provide meals in congregate settings or through home-delivered meals. Nutrition education is frequently a part of congregate meal service.

In addition, projects offered such services as telephone reassurance, continuing education, protective services, recreation and leisure-time activities and library services.

The following provides a list of the currently operating Areawide Model Projects and a brief description of each:

Maine.—The designated project area includes the counties of Androscoggin, Franklin, and Oxford, located in Central West Maine, and combining rural and urban areas. The area also includes a Model City. The Project focus is on improving

accessibility of services for the elderly. The Project is notable for advanced statewide planning effort and commitment of State and community support. The project is operated directly by the State Agency.

Mississippi.—The project area includes the coastal counties of Hancock, Harrison, and Jackson. This area was hard hit by Hurricane Camille several years ago and affected many elderly persons who lost their homes and are not yet successfully relocated. Poor housing conditions and lack of alternatives to institutional care have resulted in the project's focus on developing alternative living arrangements for these elderly persons affected. The State Agency has contracted with the Southern Mississippi Economic Development District for the conduct of the Project.

Nebraska.—The designated project area includes the city of Lincoln and Lancaster County. The Project seeks to develop alternatives to unnecessary institutionalization of older people which has been a major problem, Statewide, for some time. The project is operated out of the Office of the Mayor of Lincoln, with whom the State Agency has contracted for conducting the project.

Texas.—The Project area is the City of Houston. The Project has identified the isolation of the elderly as the major problem. It is attacking this problem through the development of services to prevent institutionalization, services to elderly in crises situations, and services to elderly in nursing homes. The area includes a significant number of older Mexican-Americans. The State Agency operates the project directly.

Utah.—The Project area encompasses Salt Lake County, which includes a Model City in the city of Salt Lake. The Project seeks to develop preventive methods for unnecessary institutionalization of older persons because of the lack of alternative living arrangements. The project is also working to develop in-home supportive services. The State Agency has contracted for the conduct of the project with the Salt Lake County Council on Aging which has been an effective instrument in the past for addressing elderly needs.

Virginia.—The project area encompasses the Southeastern Virginia Planning District #20 including the cities of Norfolk, Chesapeake, and Portsmouth. Norfolk is also a Model City. The State Agency operates the program directly. The Norfolk Health, Welfare, and Recreation, Planning Council conducted the activities related to program planning. The project seeks to aid isolated and withdrawn older people and provide new services and programs, or to make sure existing ones are more accessible. Effort has been made to involve the large population of elderly Blacks residing in the area.

Oregon.—The project area encompasses the city of Portland and Multnomah County. The project seeks to develop alternatives to institutionalization of the elderly through improved social services, designed to delay or prevent physical and mental deterioration. In addition to the Administration on Aging Areawide grant, the Model City Agency in Portland is making a major commitment of funds and the City-County Commission on Aging is providing support of staff and resources. The State Agency has contracted with the Commission for the conduct of the Project.

Puerto Rico.—The selected area includes Rio Piedras within the San Juan Urban Renewal District. The project is focusing on the problem of isolation of senior citizens. The older residents of the area have extremely low per capita incomes and are in need of services, particularly those related to health. Commonwealth support and wide community participation has been achieved. The project is operated directly by the State Agency.

South Carolina.—The project area includes the six counties of South Carolina's Appalachian area—Anderson, Oconee, Pickens, Greenville, Spartanburg, and Cherokee. The Project is focusing on improving the level of physical and mental health of older people, through the development of linkages with existing health and related services and the development of new services. The Project is operated directly by the State Agency.

Arizona.—The designated project area is Pima County which includes the City of Tucson. The Division for Aging of the State Department of Public Welfare has contracted with the Tucson Council on Aging, which is operating the project. The project seeks to assure that the elderly obtain needed ongoing health services, with the objective of preventing institutionalization. Tucson has an experimental Model Cities health project for the elderly which was conceived in conjunction with the Tucson Council on Aging.

Louisiana.—The City of New Orleans is the designated project area. The Louisiana Commission on Aging operates the project with support from the Metropolitan Council on Aging. The project seeks to reduce physical and social isolation and to reduce institutionalization.

New York.—The designated area embraces Onondaga County which includes the City of Syracuse. The State Office for the Aging has elected to operate this program through contractual arrangements with the City of Syracuse, the Metropolitan Commission on the Aging. Statewide planning efforts are well integrated into this project. The focus of the project is the elimination of isolation and loneliness among the elderly. The project area includes a Model Cities program.

Rhode Island.—The Department of Community Affairs, Services for Aging, operates this project directly on a Statewide basis. The focus of the project is health maintenance for the elderly in order to prevent or delay the incidence of physical and mental dysfunction. The project area has two model Cities which have made sizeable commitments toward conducting the Areawide Model Project.

Washington.—The project area includes the City of Seattle. The State Council on Aging of the Department of Social and Health Services has chosen to contract with the Council on Aging for Seattle and King County to conduct the Project called Project Mainstay, which is seeking to improve services delivery to the homebound elderly through the stimulation of resources and the strengthening of linkages, both between the elderly and services and between the various providers of services. Seattle also has a Model Cities project.

Ohio.—The designated project area includes a part of the City of Cleveland, located in the northcentral part of Ohio. The area selected for Project "One Hundred by One Hundred" is a section of Cleveland comprised of 14 Social Planning Areas extending 100 blocks East and 100 blocks West of the Cuyahoga River. The project seeks to develop alternatives to unnecessary institutionalization of older people. The Ohio Division of Administration on Aging has contracted with the City of Cleveland for the conduct of the project.

Wisconsin.—The project area includes the City of Racine, located in the southeastern part of Wisconsin. The project is focusing on the problem of isolation and the increasing dependency of the elderly. Inadequate transportation has also been identified as a major problem to receive primary emphasis in project operations. The Wisconsin Division on Aging administers this project directly.

Georgia.—The selected area for this project is the City of Atlanta which covers Fulton County and a portion of De Kalb County. Atlanta has a Model Cities grant which has programs specifically for the elderly. The project seeks to provide alternatives to institutionalization. The Georgia Commission on Aging has elected to operate this program directly on a temporary basis.

Hawaii.—The Hawaii Areawide Model Project area includes the City and County of Honolulu limited to the Chinatown-Kapalama area within the county where the highest concentration of elderly poor reside. Also, there is a Model Cities grant for this area. The focus of the project is directed toward the elimination of the psychological, sociological, physiological and economic isolation of the elderly from the mainstream of community activities. The Hawaii Commission on Aging has contracted with the Honolulu Office of Human Resources to administer this project.

Maryland.—The project area is the lower Eastern Shore Counties of Dorchester, Wicomico, Somerset, and Worchester. The Maryland Commission on Aging operates the project which seeks to reduce the number of aged admissions to long term care facilities and to prevent needless impairment of the ability of the aging to live in the community through the delivery of services to them. They are reaching those over 60 who are members of minorities, who have low incomes, and who are isolated.

Missouri.—The project area is the City of St. Louis. The project is focusing on the provision of adequate community services to postpone or avoid institutionalization. The State Agency on Aging has contracted with the City of St. Louis for the conduct of the project.

New Hampshire.—The designated project area is the southeastern corner of New Hampshire incorporating the Merrimack Valley and Sea Coast Regions. The New Hampshire State Council on Aging operates the project, called Project Access. The project focuses on the isolated elderly who do not have access to necessary services and, therefore, are vulnerable to serious problems, which may result in early institutionalization. The proposed solution is to link these isolated elderly with necessary services.

4. NUTRITION PROGRAM

Under the provisions of Public Law 92–258, signed by the President on March 22, 1972, a national Nutrition Program for the Elderly was added to the Older Americans Act of 1965. This program is designed to meet the nutritional and social needs of individuals, aged sixty and older, who do not eat adequately because:

(1) they cannot afford to do so; (2) they lack the knowledge and/or skills to select and prepare nourishing and well-balanced meals; (3) they have limited mobility which may impair their capacity to shop and cook for themselves; and (4) they have feelings of rejection and loneliness which obliterate the incentive necessary to prepare and eat a meal alone. These and other physiological, psychological, social and economic changes that can occur with aging result in a pattern of living which may cause malnutrition and further physical and mental deterioration. During the first year of operation, it is the goal of Title VII to serve 250,000 meals on a daily basis.

The purpose of this program is to provide Older Americans, particularly those with incomes below the Bureau of Census poverty threshold, with low cost, nutritionally sound meals served in congregate settings, in strategically located centers. These centers can be located in facilities such as: schools, churches, community centers, senior citizens centers and other public or private non-profit institutions where other social and rehabilitation services can be obtained. Besides promoting better health among the older segment of the population through improved nutrition, such a program is aimed at reducing the isolation of old age and offering older Americans an opportunity to live their remaining years in dignity. Each project must provide at least one hot meal per day, five or more days per week, and each such meal must assure a minimum of one-third of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council.

Supporting social services must be available and accessible to project participants as needed. These services include: "Outreach"; Transportation; Personal Escort; Information and Referral; Health and Welfare Counseling; Nutrition Education; Shopping Assistance; and Recreation Activities incidental to the project. In order to assure that the maximum of hard-to-reach, isolated, and withdrawn eligible individuals throughout the project area have the opportunity to participate in the project, the nutrition regulations require that an ongoing outreach service be provided from each congregate meal site. The regulations also require that not more than twenty percent of a State's allotment for a given fiscal year, excluding that necessary for administering the State plan, be used for the provision of the supporting social services described above. Those supporting social services, to the extent they are needed and not already in place, must be developed within thirty days after nutrition services have been initiated. To the maximum extent feasible, the project must make every effort to utilize the existing social service resources provided by agencies such as health and mental health, public assistance, medicaid, social services, rehabilitation, education, economic opportunity, legal services, food and agriculture agencies, and Title III Community Projects, to provide the supporting social services prescribed.

During the first year of operation, it is the national goal of Title VII to serve 250,000 meals on a daily basis. However, during 1972 funds were not appropriated to begin Title VII.

In preparation for the implementation of this program, the Administration on Aging has developed plans for the training of Project Directors and Site Managers of Nutrition Programs for the Elderly. Pilot tests of the training program have been scheduled at Corvallis, Oregon in cooperation with the School of Home Economics at Oregon State University.

The State Operating Plan describes how the State agency plans to implement the nutrition program so that those target group eligible individuals in greatest need of nutrition services are served. The State Operating Plan is to designate the geographic areas in which the State Agency will operate the nutrition program during the fiscal year. The Plan is to be developed by the State Agency in two parts: (1) a State needs analysis of the population aged 60 and older by county, and (2) a more detailed analysis of need of the target population within the proposed project areas. The State Agency must set forth the characteristics of target group eligible individuals in greatest need, including specific minorities and the limited English-speaking groups designated as a minority within the State.

The State Agency must submit a report to SRS on progress made during the previous month in implementing the projects in the areas proposed for awards.

B. Training

1. Career Education in Aging

The major thrust of the Administration on Aging's training grant program, from its inception in 1966, has been to foster the recruitment and preparation of manpower required for expandng the programs, facilities. and services for older people envisioned in the Older Americans Act of 1965.

Most of the training programs were initially established at the graduate level. Support is now provided for training at baccalaureate, master's, and doctoral levels.

From the outset, institutions have been invited to submit proposals for educational programs designed to equip students for—Program planning and administration at Federal and State levels; Community development and coordination; Senior Center direction; Architectural design; Teaching and research; Management of retirement housing; Administration of homes for the aging; Recreation leadership; Adult Education; and Library service.

Each career-oriented training program included an intensive practicum of 3 to 9 months. Students and graduates have demonstrated to program agencies the value of personnel having systematic knowledge of the aging processes and of older people. Consequently, most graduates of the training programs have readily found employment in the field.

The number of institutions with AoA-supported career training programs increased from 8 in 1966–67 to 47 during the current 1972–73 academic year. The table identifies, by Federal Regions, the institutions which received support for such programs from FY 1972 funds. The first column identfies institutions offering interdisciplinary education for one or more of the priority areas listed above, with specialization in gerontology. Additional institutions within which schools of social work are preparing sstudents for community development to meet the needs of the older population are listed in the second column

Through June 1972, the programs inaugurated between 1966 and 1970 had produced more than 600 graduates. The number of career students enrolled during the 1972–73 academic year is approximately 1,000. A detailed evaluation of the first 5 years of the career training will be completed during 1973.

Undergraduate Education

In FY 1971, the Administration on Aging made several awards to support training at the baccalaureate level for service personnel in the aging field. In FY 1972, such support was extended to 21 undergraduate programs with approximately 350 students. Institutions offering undergraduate training only or as components of broader programs are designated by the letter "U" in the table.

EDUCATIONAL INSTITUTIONS PROVIDING CAREER TRAINING IN AGING WITH 1972 SUPPORT FROM THE ADMINISTRATION ON AGING

[(U) designates undergraduate programs or programs having an undergraduate component. (M) designates programs addressed primarily to minority students]

Federal region—	Type of program	
	Interdisciplinary with specialization in gerontology	Social work: Community development concentration
I	Brandeis University	University of Maine at Portland-Gorham (U).
II	Columbia University, Teachers College; Syracuse University (U).	Fairleigh Dickinson University (U-M).
III	Federal City College (U-M); Pennsylvania State University (U).	West Virginia University (U).
IV	Albany State College (U-M); Duke University; Fisk University (M); University of North Carolina; University of South Florida (U).	Livingstone College (U-M).
V	Miami University (U); University of Michigan-Wayne State University; University of Minnesota.	University of Chicago; University of Wisconsin.
VI	University of Arkansas at Little Rock (U); Bishop College (U-M); North Texas State University (U).	Our Lady of the Lake College (U-M); Southern University in New Orleans (U-M).
VII	Kansas City Regional Council for Higher Education (U); [1] University of Nebraska at Omaha (U); St. Louis University (U).	
VIII	Rocky Mountain Gerontology Center (U) [2]	Adams State College (U-M); University of Wyoming (U).
IX	University of Arizona; University of Southern California.	University of California at Berkeley; California State University, San Diego.
X	University of Oregon (U); Oregon State University (U); Portland State University (U). [3]	University of Washington (U).

[1] KRCHE represents a consortium of 16 Kansas City area universities and colleges, of which 5 work with the Urban Center (Kansas City, Mo.) in offering interdisciplinary courses and fieldwork in gerontology. These 5 are Donnelly College, Tarkio College, Benedictine College, Missouri Valley College, and Rockhurst College.

[2] The center involves 5 institutions: the University of Utah, Brigham Young University, Southern Utah State College, Utah State University, and Weber State College.

[3] The 3 programs have been funded jointly.

Education of Minorities

Administration on Aging-supported programs have been required, from the beginning, to make special efforts to recruit students from all minority groups. In FY 1971, training grants were made to six black colleges. The Fy 1972 appropriation made it possible to support minority-focused training in 3 additional colleges and universities. The program in minority institutions or otherwise focused on minority students are designated in the table by the letter "M."

Two FY 1972 awards were made to support short-term training for faculty of minority schools entering the field of aging. Another grant is designed to result in the compilation of teaching materials about elderly blacks for use particularly in these programs.

2. MULTIDISCIPLINARY CENTERS IN GERONTOLOGY

The expanded FY 1972 appropriation enabled the Administration on Aging to move further toward assisting at least one major institution within each region to establish a multidisciplinary gerontological center. The underlying AoA objective grew out of the recognition that three such centers—at Duke University, the University of Michigan-Wayne State University, and the University of Southern California—were making a variety of significant contributions to the emergence of aging programs, nationally and within the geographic areas they served. In each instance, the institution was engaged in gerontological research, in providing educational preparation for several career areas in aging, in conducting evaluative studies, conferences and short-term training, and in offering technical assistance and consultative services.

The pattern evolving at these institutions, and soon emulated by others, seemed promising in view of the expected nationwide expansion of programs in aging and increasing responsibilities of Regional Offices and State and community agencies. Accordingly some 1972 funds were apportioned among several of the institutions listed in the table to enhance their capabilities for performing the functions listed above. Most of these institutions have created centers or institutes having broad approaches to the field of aging and eager to serve the areas in which they are located. A concept paper entitled "Multipurpose Gerontology Centers" was prepared by the Division of Manpower Development staff and presented at the 25th Annual University of Michigan Conference on Aging in September.

A 1972 grant was made to an ad hoc group of educational institutions having programs in aging to enable them to consider in depth how educational resources may best contribute to the field.

3. SHORT-TERM TRAINING

Previous reports have described the continuing AoA-sponsored short-term training offered by the University of Georgia, the University of Michigan, and the University of Southern California. The 2 to 6-week University of Southern California program and the 14-week Residential Institutes of the University of Michigan have provided intensive education in gerontology and in a variety of skills to several hundred persons recruited from the entire United States. The University of Georgia short-term courses have been addressed to retirement housing personnel throughout the southeast.

During the early years of the program, the focus on career preparation left few resources for support of short-term training. The mid-year addition to the FY 1972 appropriations made it possible, as already noted, to provide much more support for a variety of short-term projects. Grants were made to the University of Pennsylvania, the University of Michigan, and Oregon State University, respectively, for the development of training materials and guidelines in the three areas of state planning, area planning and nutrition project operation.

Two additional awards were made for curriculum development and pilot short-term training. The National Center for Housing Management, created by Executive Order early in 1972 to provide management training, was given an AoA grant to cover the cost of including specialized content on aging for managers of housing for the elderly. A grant to the National Paralegal Institute is being used to develop materials for training older persons to serve as paralegal personnel in neighborhood legal centers. It is expected that the curriculum packages being developed under these awards will be available for nationwide use by community and junior colleges and other adult education facilities.

Of the FY 1972 appropriation, $500,000 was apportioned among the ten Regional Offices for discretionary use in support of short-term training initiated within the regions. The formula-based allotments were used for projects designed to meet specific needs of a wide range of professional and paraprofessional personnel in the fields.

4. OTHER SPECIAL PROJECTS

Several additional projects with exceptional potential significance were supported with FY 1972 funds. An award to the American Association of Community and Junior Colleges is enabling the association: (1) to compile an inventory of the extent of involvement of its 1,100 member colleges in the field of aging; (2) to develop curriculum models for preparing semiprofessional personnel for the field; and (3) to bring college personnel together with State and local aging agency personnel in order that they may develop mechanisms for collaboration.

A somewhat parallel grant was made to the Adult Education Association for the Two-fold purpose of (1) compiling information about the extent to which adult education programs are reaching older people and (2) collecting and summarizing scientific knowledge about educational programs for older adults. It is hoped that this project, too, will result in involving increasing numbers of educational agencies in serving older adults.

A small grant was made to the International Center for Social Gerontology in partial support of an international symposium on Housing and Environmental Planning for Older Adults. The symposium will be held in Washington, D.C. in the fall of 1973.

Looking toward the development of systematic procedures for bringing positions in aging and program graduates together, an award was made to the Institute for the Study of Inquiring Systems to examine the feasibility of establishing a placement service for the field of gerontology.

C. Information Activities

Calendar year 1972, following the White House Conference on Aging in late 1971, was designated the year of action for older Americans. As the year began, expectations and interest were at fever pitch and an increasing number of inquiries and requests for materials were received by the Information Division.

1. CONTINUING CONFERENCE ACTIVITIES

The Division took over public information chores for the White House Conference on Aging during January 1972. In March and April, it planned, scheduled, announced, and manned a series of 7 press conferences for Dr. Arthur S. Flemming, Chairman of the Conference, at which he released recommendations of individual Sections and Special Concerns Sessions of the Conference.

The Division edited, designed, and prepared for the printer 23 interim reports on these recommendations, preparing draft versions for the press conferences, and formal printed copies for general distribution. Each contained not only the recommendations of the particular Section or Session but all related recommendations as well. A total of 10,000 were ordered for free distribution by AoA, with additional thousands sold by the Government Printing Office. A special set of the 23 interim reports was prepared for the President. The Division also designed, edited, and prepared for the printer the official two-volume final report of the Conference.

2. SENIOR CITIZENS MONTH

Senior Citizens Month, May 1972, featured a followup theme for the Conference—Action Now. A poster based on this theme, a Presidential Proclamation, radio and TV spots, and a special media feature story-calendar were developed for distribution. The latter reported on activities throughout the Nation which were taking place every day of the month of May and was widely used. A visual calendar showing high spots of the story was also prepared and distributed to media.

Aging featured the poster and theme and carried special stories on the President's Message on Older Americans, the new Nutrition Program for the Elderly, and the Advisory Committee on Older Americans. The Advertising Council supported the Division's special program, featuring it in its *Public Affairs Media Bulletin*. In addition three of the five films produced from the White House Conference multimedia presentation were distributed to State and regional offices on aging before the Month began and two more followed later.

3. OTHER MAJOR PUBLICATIONS

Throughout the year, the magazine *Aging* carried "The Post-Conference Action Year" banner on its masthead. Eight issues were published in 1972.

In the spring the Federal Editors Association awarded its first place for a popular publication in two or three colors to *Invitation to Design A World: Second Reader, 1971 White House Conference on Aging.* The *Second Reader* had been the Senior Citizens Month preprinted supplement to *Aging* in May 1971.

To meet the greatly increased requests for publications on nutrition following the enactment of the Nutrition Program for the Elderly (P.L. 92–258) as title VII of the Older Americans Act, 14 additional final reports of AoA nutrition projects were published in the Administrative Papers series. *A Home Delivered Meals Program for the Elderly,* the report of the only AoA nutrition project with its primary focus on this method of providing nutrition to the elderly, was published as a separate major publication.

A series of manuals on information and referral, developed under an AoA research project, were published for the use of the national information and referral demonstration project located in the State of Wisconsin, and also were made available to others requesting this type of information.

The Division also published *A Summary of Selected Legislative Proposals Affecting Older Americans,* prepared by the Office of Legislative Affairs, and the *Manual of Policies and Procedures for the Nutrition Program for the Aging,* in addition to a number of revised and reprinted publications.

4. OTHER INFORMATION ACTIVITIES

Interest in aging, greatly stimulated by the 1971 Conference, provided the Division with expanding opportunities (and demands) for media cooperation. Some high points of the year were:

Assisting the Secretary and Commissioner in preparing special articles for *Food Management.*

Assisting the Commissioner in preparing article on "Aging in Russia" for *ACTION Newsletter.*

Information provided for articles in *Ladies Home Journal, Changing Times, New York Times, Wall Street Journal, Milwaukee Journal, Washington Star, Washington Post, Phoenix Gazette, Christian Science Monitor, Philadelphia Inquirer, National Observer, National Restaurant News, CNI Weekly Report,* and *Washington Report on Long-Term Care.*

Time and information were contributed to NBC for various Today shows, *Baltimore Sun,* UPI and AP special stories, follow through with specialty press first contacted for the WHCOA segment reports.

The Division planned, arranged, scripted and rehearsed a 30-minute segment of the NBC series, "There's No Place Like Home," which featured Administrator Twiname, Commissioner Martin, and the directors of two AoA nutrition programs; worked with SRS staff to prepare a TV spot entitled "To Find the Way," symbolizing the difficulties older people have finding services; working with SRS staff, edited and re-scored two radio spots on aging; prepared outline script in detail for Secretary Richardson, Commissioner Martin, and WHCOA Vice-Chairman, Bertha Adkins, for a TV taped report by the Secretary to the HEW Regional offices.

The Division also prepared several slide presentations, including one on "Let's End Isolation" with a 5 to 10 minute narrative script, and participated in major discussions with the Public Broadcasting System and the Corporation for Public Broadcasting in preparation for a continuing series for older people.

Press releases during the year included two on the regulations for the Nutrition Program for the Elderly, several on research and demonstration grant awards of particular interest, and one each on new appointments to the Advisory Committee on Older Americans and the establishment of the Technical Advisory Committee on Aging Research.

D. Inter-Agency Coordination

During 1972 the Administration on Aging continued to pursue joint action with other HEW agencies under the Secretary's priorities established in 1971. The general thrust of the effort was "to strengthen services to the aged" through

coordinated approaches "using all relevant resources to deliver health and social services to our older citizens, thus enabling them to lead full and active lives".

The three HEW agencies selected by the Administration on Aging for special concern were the Health Services and Mental Health Administration, the Social Security Administration, and the Office of Education.

Following up on meetings held with HSMHA in 1971, AoA staff and HSMHA staff developed an interagency agreement which was signed by the Administrator of HSMHA and Commissioner of AoA in May. General purpose of the agreement is "to provide a framework within which to structure joint efforts on consultations and sharing of expertise, coordination of planning and funding strategies, planning and implementation of service delivery programs, and recommendations for future program directions". Under the agreement each signer designated a senior staff person to coordinate joint activities and made similar designations at the regional level. Areas cited for collaborative efforts were research and demonstration activities. manpower and training programs, program development, and planning for high priority areas, both programmatic and geographic.

Under the agreement AoA and HSMHA have jointly funded seven research and demonstration projects, have met on joint action for manpower and training, have worked closely on such program areas as long term care and alternatives to institutionalization, and are working on a joint objective calling for HSMHA regional staff to assist in Areawide Model programs, utilizing all available HSMHA local programs such as mental health centers, community health centersnk HMOs, alcoholism prevention programs, and experimental health delivery services. This latter activity followed a meeting of HSMHA regional coordinators on aging with HSMHA and AoA central office staffs.

With the Social Security Administration AoA has worked closely on the matter of information and referral services mandated by the President in his speech to the White House Conference on Aging delegates. Jointly SSA and AoA have met with the United Way of America on community information and referral services and are cooperating in a statewide research and demonstration project in Wisconsin testing various information and referral systems. Within the Social and Rehabilitation Service, AoA has been working for coordination of information and referral requirements by the several bureaus with the Social Security information and referral system. In addition, AoA and Social Security began to work together on the matter of Supplemental Security Income for the aged as soon as H.R. 1 was passed. AoA and Social Security had discussed the possibility of using older volunteers as representative payees for patients in nursing homes, based on early reports from a research and demonstration project funded by AoA in cooperation with the Social Security Administration. Later evaluation of the project showed that volunteers had not succeeded as representative payees. Possibility of using older persons on a reimbursed basis for expenses was explored, but trust funds could not be used for this purpose. Exploration is continuing with ACTION on the possible involvement of R.S.V.P. participants in such a program.

Exploration with the Office of Education on possible linkages with AoA begun in 1971 continued into 1972. It became evident that most educational programs which might benefit older persons were those at the community level, except for possible joint funding of research and development programs to explore educational desires of older persons. Funds within the Office of Education for research programs were committed until the fiscal year 1974, so AoA deferred temporarily its plans for joint funding. The Office of Education promised to use its influence with administrators of state and local programs for the inclusion of older persons. Under Title V of the Older Americans Act a grant of $185,955 was made to the American Association of Junior Colleges to find out what Junior and Community Colleges were doing in the way of services to the elderly, training of personnel to work in aging programs, and training of older persons themselves. This was continuing at the year's end.

Appointment of a Special Assistance to the Secretary of Housing and Urban Development for the elderly and handicapped opened the door for closer collaboration between AoA and HUD. Further assistance for coordination of activities came as the result of a cooperative agreement between HEW and HUD and through the appointment of HUD specialists for housing for the elderly in regional offices, representing housing production and mortgage credit, housing management, community development, and community planning and management. Special training

was given these appointees. In addition, AoA, HUD, ACTION, and the National Center for Voluntary Action agreed to cooperate in providing volunteer opportunities for older persons living in federally subsidized housing.

Following earlier joint funding of research and development grants by the Department of Transportation and the Administration on Aging, the two were collaborating at year's end on a joint funding strategy for the fiscal year 1973. Together they also began efforts during 1972 on implementation of the President's directive that all grant programs include transportation for those receiving service. Discussions were broadened to include other bureaus in the Social and Rehabilitation Service administering grant programs to the elderly and handicapped. DoT also strengthened provisions that community transportation plans include provision for the elderly.

Late in the year the Administration on Aging and the Veterans Administration officials began discussing ways in which they might jointly assist both older veterans and older persons generally. Possibility was being explored of the involvement of Veterans Administration staff from the various facilities across the nation in the planning and development of services in the Areawide Model Projects. Basis for the discussions was the expectation that VA expertise would strengthen local efforts and the development of coordinated comprehensive service programs for the elderly would facilitate discharge of older veterans to their communities.

E. Nursing Home Improvement

The Administration on Aging continued its concern for the condition of patients in nursing homes with the Secretary's Office of Nursing Home Affairs. In this connection, AoA has been represented on the interagency workgroup which developed five models for the nursing home ombudsman demonstration projects, then selected the demonstration sites, and periodically reviews the progress of the demonstrations. The five projects are located in Idaho, Michigan, Pennsylvania, South Carolina, and Wisconsin. Through the collaboration of the Secretary of Elder Affairs in Massachusetts, AoA, and HSMHA a sixth project was funded in Massachusetts late in the year.

AoA is also represented on the Long Term Care for the Elderly Research Review and Advisory Committee, organized by the Office of Nursing Home Affairs and staffed by the National Center for Health Services Research and Development, HSMHA. Some of the joint AoA and HSMHA funding of projects described under Interagency Coordination resulted from this activity. One such is the home care demonstration unit funded in Worcester, Massachusetts.

F. Church Activities

The initial overtures of the Administration on Aging in 1969 to solicit cooperation from the leaders of religious bodies to engage in joint ventures in behalf of the older citizen was climaxed in 1972 by the formation of the National Inter-Faith Coalition on Aging. The 1971 White House Conference on Aging recommendations on Spiritual Well-Being also gave important impetus to this development. Initially, a steering committee was called into being to unite the religious forces into a single undergriding force to promote the well-being of the older American.

Invitations to join the movement were then sent to all religious bodies of America. Catholic, Jewish, and Protestant church groups sent delegates to the organizational meetings, which resulted in the Coalition. Participation includes 24 religious communions, with more than 96,000,000 constituents and 334,000 clergy members. Supported by a Research and Demonstration grant from the Administration on Aging, the Coalition's initial effort will be directed toward a complete catalog of Church related activities in behalf of the elderly.

The Indiana Institute on Religion and Aging, conceived and developed by the Indiana Council of Churches and the Indiana Catholic Conference following earlier technical assistance from AoA, worked with the Indiana Office of Aging, to conduct a Seminar on "Death and Dying" at the Center for Continuing Education of Notre Dame University, in October, 1972. It was the first annual conference of the Institute and attracted participants from Indiana, Illinois, Michigan, Pennsylvania, and New York.

A further action of the Institute was the development of a Seminar at the Christian Seminary in Indianapolis on "Ministering to the Aging" to be held in January, 1973, for members of the clergy, social workers, and seminarians.

G. Pre-Retirement Planning

AoA continued to assist Federal departments and agencies in the planning and presentation of retirement planning programs for employees. As the result of this experience the Commissioner recommended that the Secretary initiate a departmental retirement planning program. Following discussions among the agencies then offering such programs, the Secretary on September 1, 1972 issued an addition to the HEW personnel manual in which the Department instituted a policy to "make available retirement planning seminars and individual counseling to all employees within five years of retirement eligibility". AoA staff worked with the Secretary's staff and Civil Service Commission personnel in the development of back-up materials.

H. Evaluation Activities

The Administration on Aging has continued to place increased emphasis on the assessment and evaluation of its programs.

During FY 1971–72 all States conducted studies of the status and needs of the elderly. AoA is conducting an evaluation of these studies and their use. The result will be an increased understanding of the results of these studies and their use.

In collecting these data, some 30 States used a social indicators questionnaire developed for AoA. Evaluations of the questionnarie and its related social indicators weighting system are in process, to be completed by the end of 1973.

The evaluation of the community projects programs (under Title III of the Older Americans Act) is completed. The contractor is preparing an executive summary of the final report.

An evaluation of the Title V Career Training Program in Aging is in process. This study will attempt to measure the effectiveness of the Title V program in attracting students into the field of Aging and determine the number of graduates of the program that are actually employed in the field of Aging. This study will be completed in April of 1973.

I. Office of Legislative Affairs

The principal activity of AoA's Office of Legislative Affairs during 1972, in addition to providing legislative research assistance to all components within the Administration on Aging as well as outside professional groups involved in Aging, was its work on proposals to amend the Older Americans Act and to extend the authorizations of its grants and contract programs. Until the Administration's proposal in this area was transmitted to Congress during March, AoA's Office of Legislative Affairs represented the Commissioner and the Agency in working out the details of the Administration bill, which was introduced as S. 3391 by Senator J. Glenn Beall, Jr. (R.–Md.) and as H.R. 13925 by Congressman Ogden R. Reid (D.–N.Y.). Thereafter, the Legislative Office was heavily involved in consideration of this and related proposals by House and Senate committees and the conference committee. Late in the year, after the President withheld his approval from the measure passed by Congress, the Legislative Office began preparing for consideration by Congress of Legislation of this general type during 1973.

The Office of Legislative Affairs during 1972 prepared and published a "Summary of Selected Legislative Proposals Affecting Older Americans", covering measures introduced in Congress between January 22, 1971 and April 1, 1972. OLA also prepared and published a compilation of the Older Americans Act of 1965, as amended through September 19, 1972.

J. Statistics

Cooperative arrangements with the Census Bureau were continued and reinforced. These centered on exploitation and distribution of data concerning older people from the 1970 census enumeration and the monthly Current Population Surveys. In this connection, a flow of data resources to the State Agencies on Aging was maintained.

A problem with 1970 census data arose from a mechanical error in the Census Bureau that produced a total figure of more than 106,000 centenarians in the United States, whereas most actuaries and demographers estimate that there are a maximum of less than 6,000. The excess count of some 100,000 represent persons of all ages who were erroneously counted as centenarians. It not only destroys the usefulness of any tabulation of the characteristics of centenarians, but also

has an impact on the analysis of characteristics of persons in larger summary age groups, as follows:

Age group	Number of persons reported by census	Percent "centenarians"
100 plus	106,441	100.0
95 plus	179,517	59.3
90 plus	492,754	21.6
85 plus	1,510,901	7.0
80 plus	3,795,212	2.8
75 plus	7,630,046	1.4
70 plus	13,073,877	.8
65 plus	20,065,202	.5

The conclusion would be that analyses of the characteristics of summary age groupings older than 85+ are unreliable and that the 85+ grouping should be used with caution.

Another problem area results from effort to support the thrust of the legislative proposals for amending the Older Americans Act which stress, and provide financial assistance to, sub-State planning for comprehensive and coordinated services to older persons. In an effort to support State and local planning operations by helping provide "small area" data as an essential input to the planning process, the Division has been active in determining what the Census Bureau publishes, what it will prepare under contract, and what it sells in the form of computer (magnetic) tapes that carry partially summarized data. This information and related information on other sources and on the organized census users tape processing centers scattered across the country have been made available to the State agencies on aging.

In addition, considering the savings and efficiency of a large scale and centralized approach to data processing, the Division has been negotiating with the Office of Economic Opportunity and the Department of Housing and Urban Development with a view of designing "small area" tabulations (primarily counties) that will serve a larger number of purposes.

Provisions in the proposed legislation (amendments to the Older Americans Act) and in the enacted legislation (Nutrition Program, Title VII) establish 60 years of age and over both for eligibility for services and as the base for the State allotment formulas rather than the former 65 and over. Data on the characteristics of the 60–65 age group are very scarce. What data are available tend to indicate that the individuals aged 60–64 are quite different in important aspects from those aged 65+. For example:

	65+	60–64	Percent 60–64 of 65+
Men in labor force (percent)	25	74	----
Women in labor force (percent)	10	36	----
Persons (millions, mid–1970)	19.3	8.4	44
Percent in families	69.8	81.6	51
Percent living alone or with nonrelatives	30.2	18.4	27
Percent who are spouses	20.4	32.3	69
Percent female relatives of head but not wife	9.0	3.8	18
Number living in "poor" households (millions)	4.7	1.1	24.3

The Division responded to hundreds of requests for data, for technical assistance, and for consultation in related areas of research, analysis, planning, studies, resources for training and institute activities, and special analyses or presentations. Requests orginated from within public agencies at the Federal, State, and local level, and from private profit-oriented and nonprofit entities.

During the year, an informal statistical memorandum series was developed to supplement the more formal "Facts and Figures on Older Americans" series since the latter requires more expenditure of man-hours and funds. Subjects covered thus far include:

1. Older Persons of Spanish Origin;
2. Bureau of Labor Statistics Retired Couples Budget;

3. Authorizations in HR 15657 (Amendments to the Older Americans Act);
4. Utilization of Short Stay (General) Hospitals in 1969;
5. Rehabilitation of Older Persons;
6. New Commercial Service—Selecting a Place to Retire;
7. Older Persons in the Voting Age Population;
8. Conversion from 65+ to 60+ Age Groupings;
9. Newspaper Report on Increasing Life Span;
10. BLS Retired Couple Budget (1971); and
11. Cumulative Impact of Inflation.

ITEM 3. ATOMIC ENERGY COMMISSION

FEBRUARY 6, 1973.

DEAR SENATOR CHURCH: In response to your request of December 15, 1972, we are pleased to submit the enclosed information describing the Atomic Energy Commission's program of research on aging for inclusion in "Developments in Aging—1972."

As in the past, this Agency has continued to support research on biological aging, with special emphasis on the relationship between the late somatic manifestations of radiation injury and the degenerative changes that occur as a part of the aging process. Our report of a year ago emphasized studies involving human populations. In the present program summary, an attempt is made to describe all areas of our research program that relate to aging and senescence.

During fiscal year 1972, a total of $5.2 million was allocated for the support of research on aging at twelve AEC-owned (onsite) laboratories and twenty-two offsite contractor facilities. The projected level of funding for fiscal year 1973 is $4.5 million.

Since the distinction between research on aging and studies in certain other areas is ill-defined and arbitrary, a number of investigations not considered a part of our program on aging are, nonetheless, contributing to a better understanding of senescence and diseases associated with advancing age. Brief mention of a few of these studies is included in the accompanying report. During the coming year, a review of all research on aging and related areas will be conducted. A somewhat revised categorization of the program of research on aging is expected to result from this review.

We hope the information provided will be of value to the Committee. Please let us know if we may be of further assistance.

Sincerely,

S. G. ENGLISH,
(For General Manager).

[Enclosure]

PROGRAM OF RESEARCH ON AGING SPONSORED BY THE ATOMIC ENERGY COMMISSION IN 1972

As part of a broad-based effort to insure the radiological safety of nuclear energy activities, the Atomic Energy Commission has for many years sponsored a comprehensive program of biomedical and environmental research to assess hazards associated with man-made radiation and naturally occurring radioactive materials used by man. A major goal of the biomedical research is to define human radiosensitivity in quantitative terms, develop a capability for estimating the biological costs of nuclear energy, and devise means of reducing the severity of radiation injury in man. Of particular interest at the present time is the study of long-term somatic and genetic effects of ionizing radiation in livirg systems, such as may arise as a consequence of exposure to radiation from an external source or from internally deposited radionuclides. This report will deal primarily with those investigations that are concerned with biological aging as it relates to, or is a component of, late somatic manifestations of radiation injury.

The late somatic effects represent a delayed expression of latent, unrepaired radiation damage in living tissue. Information on these irreversible effects is gained from animal experimentation, epidemiological surveys of irradiated human populations, and studies (usually retrospective) of occupational and medical exposures. From past studies, the main types of late somatic effects are known. They are expressed as specific diseases in particular organs, functional impairment

or other abnormalities in particular organs, a generalized deterioration in all organs, and life shortening. The diseases and lesions that develop as a part of the late somatic response are not unique to radiation stress; that is, they are qualitatively similar to manifestations of biological deterioration that arise spontaneously in unirradiated populations from natural aging or other causes. Because of this lack of uniqueness, the causal relationship between radiation stress and late somatic effects is generally obscure, particularly so in view of the protracted period of latency that typically separates the two. Establishment of a cause-and-effect relationship can be accomplished only at the population level by the use of statistical methods. Thus, the late effects are identified and studied as statistical deviations from the norm in long-term (frequently lifetime) investigations involving very large populations. Studies of this sort, especially when conducted on a prospective basis, require years for their completion. Therefore, information on the late somatic effects accumulates slowly.

Important insights have emerged from long-term studies in animals. Since late somatic effects are not unique, the causes of death in sublethally irradiated populations are essentially the same as those seen in aging populations under normal circumstances. However, in irradiated populations there occurs an increase in the absolute incidence of certain diseases, an advancement in the time of appearance of many disease and other degenerative lesions commonly associated with senescence, and a decrease in life span, all roughly in proportion to the magnitude of the radiation dose. Neoplasms (cancer and leukemias) have been identified as the main cause of radiation-induced life shortening. The reduction in life span as a result of nonneoplastic lesions is generally small by comparison and is associated with the early onset of a variety of common diseases and, therefore, with nonspecific mortality. This nonspecific type of response is not yet fully understood, but it has been postulated that the underlying cause may be a generalized, subclinical deterioration occurring in all tissues as a consequence of radiation damage.

On the basis of the limited data available, it appears that the late somatic response in man resembles that described in animal species. However, nonspecific lifeshortening has not yet been unequivocally demonstrated in sublethally irradiated human populations.

Because sublethally irradiated animals (and possibly humans as well) die prematurely from degenerative diseases closely resembling those associated with senescence, it has been suspected that radiation may cause life shortening by accelerating the natural aging process. Nonspecific life shortening and the early onset of common diseases, as seen in irradiated animals, are thought to be particularly suggestive of accelerated aging. However, as data have accumulated, more and more differences between irradiated and aging animals have been noted. Therefore, the concept of radiation-accelerated aging remains an unproved hypothesis that requires further testing.

Current research is directed toward the goal of obtaining a better understanding of the late somatic effects, including their relationship to the degenerative processes responsible for senescence. For practical reasons, the major research effort is concerned with the collection of information on the manner in which factors such as genetic makeup, age at time of exposure, superimposed stress, and various radiological parameters influence the qualitative and quantitative expression of late somatic effects. Information of this sort is essential to the formulation of radiation protection guides and the estimation of biological costs of nuclear energy activities. Data obtained may also contribute toward the more effective use of radiation in the therapy. It should be emphasized that lifetime studies of late somatic effects, even when conducted primarily for radiobiological information, frequently provide useful longitudinal data on the aging process in unirradiated control populations. Data on the clinical and epidemiological aspects of aging are valuable, in turn, as part of the total body of knowledge needed to understand the consequences in man of chronic, low-level radiation stress, such as may occur in certain occupational situations. Longitudinal data on normal patterns of disease and mortality in workers contributes toward a better understanding by helping to resolve the question of whether chronic radiation stress, when superimposed on natural aging, accelerates spontaneous degenerative processes or contributes to biological deterioration in some other way.

Other ongoing studies seek to define in greater detail the degenerative changes associated with radiation-induced life shortening and natural aging and to elucidate their underlying causes. Only by achieving a better understanding at the mechanistic level will it be possible to determine the extent to which these two phenomena share a common biological origin. These studies are also of potential

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practical importance inasmuch as only by elucidating the mechanisms underlying late radiation effects may it become possible to predict with confidence the hazards to man posed by small radiation doses.

These two lines of research entail a spectrum of activities ranging from lifetime epidemiological studies in humans to fundamental research at the cellular and molecular levels. The present status of work in these areas is summarized below. Virtually all of the ongoing studies are of a long-term nature and will continue in 1973. No significant qualitative changes in the program are expected in Fiscal Year 1973, but a modest reduction in the level of effort is anticipated. Beyond Fiscal Year 1973, an increasing trend in effort and support is planned.

Long-Term Human Studies

Long-term studies of late radiation effects in human populations are essential to an understanding of man's sensitivity to ionizing radiation. Four major efforts of this sort are now in progress.

The oldest of the human studies is a prospective epidemiological investigation conducted by the Atomic Bomb Casualty Commission (a cooperative research agency of the United States National Academy of Sciences and the Japanese National Institute of Health) to evaluate delayed radiation effects in survivors of the atomic explosions that occurred at Hiroshima and Nagasaki in August 1945. In this unique study, which began in the late 1940's, approximately 112,000 Japanese nationals are being observed to evaluate changes in body function and chemistry and to collect epidemiological data on morbidity, mortality, and life shortening. Among the wealth of longitudinal information accumulating from the study are invaluable data on late somatic effects, including nonspecific life shortening; data compiled through 1970 show no definitive evidence of nonspecific life shortening. Important information is also being obtained on various aspects of natural aging and on morbidity and mortality in the control (unexposed) population. Illustrative of the interest in aging is a study now in progress in which a chemical index of aging is being used to search for evidence of accelerated aging in the most heavily exposed population. This study entails the quantitative measurement of components of connective tissue in samples of skin and aorta removed at autopsy. In connection with the study of aging, a Symposium on Problems of Measurement of Aging in the Human Population was held in Hiroshima on May 29–30, 1972.

A similar but much smaller study is being conducted by members of the staff at the Brookhaven National Laboratory to evaluate biological sequelae in the people of the Marshall Islands who, by accident, received acute exposures (both externally and internally) from radioactive fallout released by a thermonuclear device during a test conducted in March 1954. Approximately 200 exposed individuals and a like number of unexposed controls are examined annually by a medical survey team. Functional and chemical parameters, as well as pathology, morbidity, and mortality are monitored during each visit. Because of the small size of the exposed and control groups, late radiation effects of a subtle nature are not detectable. A substantial elevation in the incidence of thyroidal abnormalities has been clearly identified as the most prominent delayed mainifestation in the exposed Marshallese population, members of which received large internal radiation doses to the thyroid from fallout radioiodine. In all cases, thyroidal pathology has been satisfactorily managed by surgery or thyroid hormone therapy. No differences in a battery of aging criteria have been noted between the exposed and control groups.

The largest of the long-term human studies is a retrospective-prospective epidemiological survey of occupational groups selected from AEC and AEC-contractor employees. This effort, which is conducted jointly by investigators at the University of Pittsburgh, contractors at several AEC-owned facilities, and a group at the Social Security Administration, was initiated in 1964 to determine if any unusual patterns of morbidity or mortality are associated with employment in the nuclear energy industry. At the present time, employment, exposure, health, and (where appropriate) mortality records are being collected on approximately 176,000 present and former workers, along with analogous data on an appropriate control population. Postmortem data on some individuals in the exposed population will eventually be obtained through the United States Transuranium Registry, which is operated by the Hanford Environmental Health Foundation. Radiological and occupational information are of primary interest in this study.

A long-term study of radium radiotoxicity in humans, which has been in progress for over twenty years at several different locations, has now been fully con-

solidated at the Argonne National Laboratory. This investigation is documenting patterns of radium metabolism, including tissue retention, and late somatic effects in individuals who accumulated body burdens of radium-226 from occupational or medical exposures before the hazards of this material were fully realized. Some 6000 persons (living and dead) are estimated to have accumulated significant radium burdens in this country. Of these, 3000 have been identified, 2000 have been located, and approximately 800 are under study at the Argonne facility. Incidences of late effects, particularly in bone, are being correlated with the magnitude of body burdens and tissue doses. The Argonne radium study is of interest in the context of aging because of the possibility that internal alpha radiation may affect degenerative processes related to normal senescence.

Long-Term Studies in Dogs

Since few populations of irradiated humans are available for study, knowledge about the late somatic effects must be supplemented by controlled experiments with laboratory animals. Over twenty years ago, the beagle dog was selected as a principal animal model for use in radiobiological research because of its intermediate size and life span, as well as other desirable characteristics. Since that time, nearly 5000 dogs have lived out their full span of years in lifetime experiments and approximately 3000 dogs are currently assigned to such studies.

Long-term studies with dogs are in progress at the Argonne National Laboratory, the Pacific Northwest Laboratory, the University of California at Davis, the University of Utah, the University of Rochester, and the Lovelace Foundation. These investigations are conducted to obtain a detailed characterization of delayed responses (primarily those manifested as late somatic effects) to external or internal radiation, as well as an understanding of the bases of the observed responses. At present, the major effort is directed toward the study of delayed effects induced by internally deposited radionuclides, both man-made and naturally occurring. Doses and dose rates in the lower range are also emphasized. In each study, multiple biological parameters are monitored in both exposed and control animals throughout the lifespan. An important aspect of these studies is the fact that they serve to evaluate the usefulness of the dog as a model of the human system.

An abundance of data on aging in the beagle has accumulated over a period of years, particularly from the Davis, Rochester, Argonne, and Utah projects. Detailed longitudinal data on patterns of diseases and histopathology are available for most major organ systems, as are data on longevity and causes of death. Information is now accumulating on changes in body function and chemistry as the beagle ages. Aging aspects are stressed to varying degress at different laboratories. An example of an active effort is that at the Davis location where investigators are seeking to quantitate age-related changes in the beagle. Neuroendocrine function, the cell-mediated immune response, autoantibody production, cellular biosynthetic capacity, rhythms in cell proliferation, and adaptation to thermal stress are among the parameters selected for study. Tentative plans have also been developed for a study of nutrient antioxidants as possible modifiers of the aging process.

Long-Term Studies of Late Somatic Effects in Other Species of Animals

Rodents

Because of their small size, ready availability, and short life span, rodents are ideally suited for use in large-scale, lifetime studies. The availability of a number of inbred strains (particularly in the case of the mouse) is another advantage in the study of late somatic effects. Extrapolations to man are generally considered more tenuous when observations are made in rodents than when they are made in the dog. Despite this limitation, rodents have proved very valuable in the development of conceptual and theoretical insights into late radiation effects of the somatic type. Moreover, data collected from rodent experiments serve as a valuable guide in the design of long-term studies in dogs and humans.

Long-term radiation studies in mice, which have been in progress for many years, are continuing at the Argonne and Oak Ridge National Laboratories. In each laboratory, studies are comprehensive in scope and seek both phenomenological and mechanistic information on late somatic effects induced by external, whole-body radiation. Both efforts are supported by strong programs of basic research on aging and emphasize conceptual aspects of the two related areas of interest.

In the Argonne study, mice are exposed to gamma radiation or to neutrons from the JANUS research reactor. The study of basic cellular and tissue mechanisms is included in the research protocol and information on natural aging processes in control populations is collected as the research progresses. In a related study, comparative aspects of late somatic effects are being investigated in a number of species of wild rodents. A unique feature of the Argonne study is the development of a mathematical theory of radiation injury and a statistical theory of mortality.

At Oak Ridge, mice from a number of species are irradiated with X-rays, gamma rays, or neutrons (fission neutrons from californium-252). Among the objectives of the study is the elucidation of the manner in which factors such as hypoxia, age at time of exposure (with emphasis on prenatal stages of development), the microbial environment, and various radiological parameters influence or modify the late somatic response. Of particular interest is research by the Oak Ridge investigators on mechanisms of radiation-induced life shortening. In one study, mice of several different genetic constitutions are being examined with respect to longevity and incidence of disease in an effort to test the concept that radiation causes accelerated aging. At doses and dose rates causing a reduction in life span of 15 percent or less, life shortening has been found to be due to specific types of neoplasms. Only when the reduction exceeds 15 percent has nonspecific life shortening been detected. Another study is seeking to determine if radiation-induced life shortening can be explained on the basis of genetic damage to somatic cells (somatic mutations).

Over a period of years, research conducted at the University of Rochester has contributed significantly to an understanding of both aging and late somatic effects of radiation. Of particular interest are investigations with rats that have provided an insight into the diffuse, subclinical, degenerative lesions that may be responsible for nonspecific life shortening in irradiated populations. Histological, angiographic, and chemical evidence obtained by the Rochester investigators suggests that radiation accelerates the development of fibroatrophy, a generalized and progressive degenerative condition associated with natural senescence. Deterioration of the microvasculature (arteriolocapillary fibrosis) arising from degeneration and necrosis of endothelial cells appears to be the cause of fibroatrophy. The end result of this deterioration is an increase in the histohematic barrier, impairment of blood flow to all organ systems, and a generalized loss of functional cells in body tissues. It is postulated that fibrotic and atrophic changes ultimately compromise body function to a point where the likelihood of death is measurably increased. Although the role of fibroatrophy in natural aging and radiation-induced life shortening is not yet fully defined, it is clear that degenerative changes in the vascular system are implicated in both phenomena.

Long-term experiments are conducted at the Los Alamos Scientific Laboratory to study late somatic effects in hamsters exposed internally (by injection) to various man-made radionuclides. Particular interest in this study centers on pulmonary effects of alpha radiation emitted by plutonium-containing microspheres entrapped in the microvasculature of the lungs. At the Pacific Northwest Laboratory, analogous studies of alpha-emitting radionuclides administered by inhalation to rats and hamsters are in progress. Similar pulmonary studies are just now getting under way at the Lovelace Foundation.

Several smaller studies with rodents seek to evaluate specific aspects of radiation leukemogenesis and radiation tumorigenesis.

OTHER SPECIES

Relatively little use has been made of animals other than dogs and rodents in long-term studies of radiation effects. Scientists at the Pacific Northwest Laboratory have developed the miniature swine as an experimental animal and this species is now being used to characterize a number of aspects of the late somatic response to radiation. Current research at the University of Tennessee-AEC Agricultural Research Laboratory in Oak Ridge utilizes cows, burros, and Shetland ponies to define functional changes, pathology, and life shortening caused by sublethal radiation exposures. Subhuman primates have rarely been used to study late somatic effects.

Basic Research on Aging

As mentioned previously, fundamental research on the causes and mechanisms of aging is basic to an understanding of the late somatic effects of radiation. In addition to developing conceptual insights, research of this nature can identify

objective, quantifiable criteria of aging that are now lacking but absolutely essential if the possible link between aging and radiation damage is to be critically explored. The major research efforts in this area are being conducted at the Argonne National Laboratory, the Oak Ridge National Laboratory, and the University of Rochester.

As previously discussed, research at the University of Rochester has defined an age-related, generalized deterioration of body tissues (fibroatrophy) which may link natural aging and somatic aspects of the delayed radiation response. The Rochester group is currently making progress in the use of specific chemical agents to modify (control) the degenerative processes responsible for fibroatrophy.

At the Oak Ridge facility, a major study seeks to identify and characterize changes in body defense mechanisms that occur as a part of the natural aging process. Current research deals with functional changes occurring in the hematopoietic, immune, and reticuloendothelial systems with advancing age in the mouse. Age-related changes in all three systems have been documented and are being further investigated. Other research at Oak Ridge is directed toward the study of functional and metabolic correlates of senescence in higher plants (including possible age-related changes in transfer RNA molecules), changes in protein coding with advancing age in the mouse, and nonspecific life shortening induced in the mouse by the LDH virus.

Research on aging at the Argonne National Laboratory emphasizes a theoretical approach. Over a period of years, the Argonne program has made many contributions at both the experimental and conceptual levels. Current research includes the study of immune competence (including "immunological acuity") in aging mice and fish. In another study, changes in the synthesis and metabolism of membranes during the aging process are under investigation. A long-term study on the comparative biology of aging is also in progress. In this study, the immune response and the composition and structure of the brain are being characterized at various stages in the life span of wild rodents. Information generated in these studies and from other sources is synthesized into new concepts, theories, and models of aging.

Investigators in other laboratories are studying free radical mechanisms as possible causes of aging (Brookhaven National Laboratory), possible effects of elevated atmospheric levels of carbon dioxide on longevity (Brookhaven National Laboratory), hormonal aspects of senescence in higher plants (Michigan State University), and cellular and membrane permeability aspects of cataractogenesis (Oakland University).

Recent progress in two basic areas of radiation research should perhaps also be noted here. Current work in the AEC-sponsored program is characterizing the types of radiation-induced damage in the DNA molecule that are subject to repair by cellular enzyme systems. Nonreparable molecular lesions (in DNA) are also being identified. It is conceivable that aging may be a consequence, in part at least, of an accumulation of unrepaired damage in cellular genetic material (DNA). Related research is directed toward the study of chromosome structure and the correlation of chromosomal damage with specific stresses (especially radiation stress). Since it is known that chromosomal aberrations increase with advancing age, this study may provide insights into the aging process and its causes.

Studies of Diseases Common Among the Elderly

Although not considered as part of the research effort on aging and late somatic effects, it may be appropriate to mention that the AEC biomedical research program includes studies on the etiology, diagnosis, and therapy of several diseases of the elderly. At the Brookhaven National Laboratory, for example, clinical and experimental studies of Parkinson's disease, hypertension, and senile osteopofosis are in progress. Applications of radiation to the diagnosis and treatment of diseases, including those associated with advancing age, are being developed in a number of laboratories.

ITEM 4. CIVIL SERVICE COMMISSION

February 15, 1973.

Dear Mr. Chairman: Reference is made to your letter of December 15, 1972, requesting information on Civil Service Commission activities for older Americans.

It has long been the policy of the Executive Branch to prohibit discrimination on the basis of age in appointments to the competitive service. Section 3307 of Title 5, United States Code, prohibits the establishment of maximum age require-

ments for entrance into the competitive service. The Civil Service Commission has made clear to agencies that this prohibition applies to promotions and reassignments as well as to initial appointments.

The Federal Government has been in the forefront of efforts to eliminate age discrimination in employment. On March 14, 1963, President Kennedy issued a memorandum to agency heads stating the Executive Branch policy barring discrimination on the basis of age for employment and advancement and extending this prohibition to Federal personnel systems outside the competitive service. In addition, the policy on equal employment opportunity for older persons applicable to the Federal Government is referred to in Executive Order 11141. That Order clearly states the policy of the Executive Branch barring discrimination on the basis of age and directs that this same policy be extended to Government contractors.

On May 5, 1971, President Nixon issued Proclamation 4050, "National Employ the Older Worker Week 1971," in which he reiterates the Administration's desire to eliminate any existing discrimination in employment because of age. The Civil Service Commission has provided technical advice on two bills which have come before the Congress—H.R. 16153 and H.R. 7130—which would prohibit age discrimination in Federal employment by statute and provide avenues for employees who allege age discrimination to seek relief.

In a memorandum dated September 13, 1972, President Nixon reaffirmed Federal Government policy prohibiting age discrimination in employment and called on Federal managers to assure that the skills and experience of older citizens are fully utilized. On September 22, 1972, the Civil Service Commission transmitted the President's memorandum to agency Directors of Personnel; and on November 22, issued internal instructions to include coverage of equal employment opportunity activities for older persons in its evaluations of agency personnel management. We are enclosing copies of the President's memorandum and related Civil Service Commission instructions.

We are also enclosing, for your information, tables of Federal Civilian Employment by Age, Sex, and Length of Service. These tables indicate that, as of June 1971, 449,899 Federal civilian employees were 55 years old or over, and 183,691 were 60 years old or over. Of those employees who were 60 or more years old, 9,153 had less than five years of service, indicating that they were hired after reaching age 55.

Our efforts during 1973 will continue to focus on assuring nondiscrimination on the basis of age in the Federal service and to identify and eliminate any direct or indirect barriers to equal opportunity for older persons. We will continue our review of agencies' personnel management operations to be sure that nondiscrimination and equal opportunity for older persons are reflected in the agencies' personnel policies and practices.

The Civil Service Commission administers the Retirement, Life Insurance, and Health Benefits program for Federal employees and their survivors under Title 5, United States Code. We are enclosing a description of these program activities as they relate to older Americans.

We hope this information will be helpful to you in the preparation of your report.

Sincerely yours,

ROBERT E. HAMPTON,
Chairman.

[Enclosures]

U.S. CIVIL SERVICE COMMISSION,
CSC OPERATIONS LETTER,
Washington, D.C., November 22, 1972.

Letter No. 273–680.
Subject: Age discrimination.

Attached is a copy of the Executive Director's memorandum to agency personnel directors transmitting a Presidential memorandum on age discrimination. The President, in his memorandum, reminded all Department and agency heads of the Federal Government's responsibility to be a leader in eliminating age discrimination and called upon them to review their agency's employment practices to identify and eliminate any barriers which prevent equal employment for older citizens.

Age discrimination in non-Federal employment is prohibited by the Age Discrimination in Employment Act of 1967 (Public Law 90–202), which became effective on June 12, 1968. The Act excluded the United States within the meaning of the term "employer" but the provisions of the Act are consistent with the President's commitment to eliminate all forms of age discrimination.

Thus, both the President and the Congress have expressed their concern about the grave employment problems experienced by older workers. In addition, the Executive Director has asked that all directors of personnel undertake a review of their agency's employment practices and forward a report on steps taken to eliminate barriers to older workers by November 3, 1972.

Advisors will review agency activities and practices affecting employment of older workers, in light of the concerns expressed above, during overall evaluations of agency EEO programs. Advisors will take steps to bring the agency into compliance with the President's memorandum and will make any recommendations necessary to eliminate discriminatory practices affecting older workers.

Appropriate instructions will be forthcoming in an early installment to FPM Supplement (Internal) 273–73.

GILBERT A. SCHULKIND,
Director, Bureau of Personnel Management Evaluation.

[Attachment]

U.S. CIVIL SERVICE COMMISSION,
Washington, D.C. September 22, 1972.

Memorandum For Directors of Personnel:

I am attaching for your information the text of a memoradnum from President Nixon for the Heads of Departments and Agencies. The President's message, dated September 13, 1972, calls attention to the government's responsibility as the Nation's largest employer to take the lead in eradicating age discrimination from employment.

Calling for reaffirmation of our commitment to the Federal Government's long-standing policy prohibiting discrimination on the basis of age, the President further asks for a review of each agency's employment practices to identify and eliminate any direct or indirect barriers to equal opportunity for older persons. You will want to undertake such a review as soon as possible, I am sure, and we would appreciate having a report on the steps you have taken in this regard by November 3, 1972. Please include any agency directives which are issued on this matter.

In connection with our overall review and evaluation of Federal personnel management, we will look to see that the letter and the spirit of the President's memorandum are reflected in agency personnel policies and practices.

BERNARD ROSEN,
Executive Director.

[Attachment]

THE WHITE HOUSE,
Washington, D.C., September 13, 1972.

Memorandum For Heads of Departments and Agencies:

For many years, the Federal Government has been fighting against discrimination in employment. On the basis of age, creed, ethnic origin, sex or skin color, discrimination is an intolerable wrong. As discrimination is an affront to our society, it cannot be countenanced in our government.

In my message to the Congress earlier this year transmitting this Administration's recommendations for action on behalf of older Americans, I stressed the importance of giving serious attention to the problems of our older citizens. One such problem is age discrimination. As the largest employer in the Nation, the Government has a special responsibility to take the lead in eradicating age discrimination from the world of employment.

It is appropriate, at this time, to reaffirm our commitment to the long-standing policy of the Federal Government that age, by itself, shall be no bar to a Federal job which an individual is otherwise qualified to perform. In doing so, I want to emphasize that our older Americans possess talents, experience, and skills which the Government needs and which our older citizens deserve the chance to contribute.

I call upon each of you to review your agency's programs to make sure that the skills and experience of our older citizens are being effectively utilized. I also ask that you review your agency's employment practices and take immediate steps to eliminate any which may directly or indirectly stand as a barrier to equal opportunity for older persons. We must not tolerate any practice that denies older citizens fair and full consideration for employment and advancement in the Federal service.

RICHARD NIXON.

CIVIL SERVICE COMMISSION

The Civil Service Commission, among other things, administers the retirement, life insurance, and health benefits programs for Federal employees and their survivors under Title 5, U.S.C.

What the Programs Did in Fiscal Year 1972

The Civil Service Retirement and Disability Fund was created to provide annuities for eligible employees who retire because of age and service or disability and for benefits to eligible survivors of employees who die in service or after retirement. About 2,623,000 active employees contributed to the Fund in FY 1972 with an average of 1,095,850 annuitants receiving benefits. Benefits totaling $1,579 million were paid to 416,000 retired employees over age 65 for an average monthly benefit of $316. This is compared to an average monthly benefit of $305 in FY 1971. For disabled former employees over age 65 benefits of $189 million were paid to 75,000 persons for an average monthly benefit of $210 compared to $203 in FY 1971, and 158,000 survivors over 65 received $274 million for an average monthly benefit of $145 compared to $134 in FY 1971.

A Federal group life insurance program is made available to active Federal employees and annuitants. At the end of FY 1972 the program covered 2,423,000 active employees and 694,000 annuitants of whom approximately 311,000 were over 65. Regular life insurance coverage is geared to the employees annual pay and ranges from $10,000 minimum to $45,000 maximum. Optional insurance is additionally available in the amount of $10,000. The employee and the Government share the cost of the regular insurance and the employee pays the full cost of the optional coverage. After meeting several requirements an employee who retires may retain his regular coverage at no further cost to himself. However, after the retired employee's 65th birthday the amounts of the regular and optional insurance are reduced by 2 percent each month. These reductions continue until the amounts of regular and optional insurance carried reach 25 percent of the amounts in force before the first reduction.

Health benefits protection is provided to over 2,209,000 Federal civilian employees and 628,000 annuitants retired after July 1, 1960 and their 5.9 million dependents under the Employees Health Benefits program. The program offers a choice of five different types of plans. Under P.L. 91–418, approved September 25, 1970, the Government contributes on behalf of employees and annuitants an amount equal to 40 percent of the current unweighted average of the high option premiums of six large plans, but not more than 50 percent of the premium costs for any particular enrollment. A separate program, the Retired Employees Health Benefits program, provides health coverage for 213,000 annuitants retired before July 1960 and their dependents. These annuitants may enroll in the Government-sponsored Uniform Plan or may purchase private health insurance from an approved carrier and a Government contribution will be made towards the cost of either. The Government's contribution on behalf of retired employees and their survivors of whom 500,000 are over 65 in both these programs was $110 million in FY 1972. Of this amount $62 million was contributed for those 65 and over.

TABLE 1.—FEDERAL CIVILIAN EMPLOYMENT BY AGE, SEX, AND LENGTH OF SERVICE, JUNE 1971 (ESTIMATED FROM THE FEDERAL PERSONNEL STATISTICS PROGRAM 10-PERCENT SAMPLE AND EXCLUDES FOREIGN NATIONALS)

[In years of service]

Age	Total		Under 5		5 to 9		10 to 14		15 to 19		20 to 24		25 to 29		30 to 34		35 to 39		40 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total (men and women)	2,761,102	100.0	641,313	100.0	598,552	100.0	404,540	100.0	343,898	100.0	300,206	100.0	321,813	100.0	139,628	100.0	2,894	100.0	8,258	100.0
Under 20	53,328	1.9	53,328	8.3																
20 to 24	264,498	9.6	227,308	35.4	37,190	6.2														
25 to 29	297,840	10.8	141,247	22.0	145,739	24.3	10,854	2.7												
30 to 34	254,632	9.2	62,412	9.7	114,429	19.1	68,430	16.9	9,361	2.7										
35 to 39	274,710	9.9	43,266	6.7	70,923	11.8	83,028	20.5	70,027	20.4	7,466	2.5								
40 to 44	326,958	11.8	37,949	5.9	71,830	12.0	66,478	16.4	78,193	22.7	62,641	20.9	9,867	3.1						
45 to 49	427,663	15.5	31,711	4.9	65,743	11.0	71,612	17.7	69,119	20.1	92,436	30.8	89,255	27.7	7,787	5.6				
50 to 54	411,574	14.9	21,341	3.3	48,112	8.0	53,786	13.3	57,864	16.8	69,282	23.1	110,768	34.4	50,387	36.1	34	1.2		
55 to 59	266,208	9.6	13,598	2.1	27,094	4.5	30,678	7.6	34,721	10.1	40,141	13.4	66,741	20.7	51,558	36.9	896	31.0	781	9.5
60 to 64	133,045	4.8	6,420	1.0	13,105	2.2	14,104	3.5	17,722	5.2	20,523	6.8	33,388	10.4	22,293	16.0	1,321	45.6	4,169	50.5
65 and over	50,646	1.8	2,733	.4	4,387	.7	5,570	1.4	6,891	2.0	7,717	2.6	11,794	3.7	7,603	5.4	643	22.2	3,308	40.1
Total (men)	1,927,465	100.0	319,994	100.0	393,010	100.0	306,478	100.0	264,177	100.0	239,013	100.0	268,817	100.0	216,122	100.0	2,400	100.0	7,454	100.0
Under 20	28,127	1.5	28,127	8.8																
20 to 24	135,080	7.0	116,509	36.4	18,571	4.7														
25 to 29	186,364	9.7	80,697	25.2	98,615	25.1	7,052	2.3												
30 to 34	177,739	9.2	31,585	9.9	84,109	21.4	54,293	17.7	7,752	2.9										
35 to 39	199,868	10.4	17,825	5.6	47,159	12.0	68,142	22.2	60,528	22.9	6,214	2.6								
40 to 44	244,029	12.7	15,252	4.8	48,721	12.4	52,132	17.0	64,892	24.6	54,441	22.8	8,591	3.2						
45 to 49	313,612	16.3	10,888	3.4	38,638	9.8	52,454	17.1	50,629	19.2	76,160	31.9	77,503	28.8	7,340	5.8				
50 to 54	313,222	16.3	7,396	2.3	28,702	7.3	38,604	12.6	41,888	15.9	54,247	22.7	95,537	35.5	46,814	37.1	34	1.4		
55 to 59	197,882	10.3	6,087	1.9	16,665	4.2	20,617	6.7	23,166	8.8	29,299	12.3	54,027	20.1	46,643	37.0	735	30.6	643	8.6
60 to 64	96,467	5.0	3,687	1.2	8,787	2.2	9,522	3.1	11,060	4.2	13,897	5.8	25,256	9.4	19,273	15.3	1,160	48.3	3,825	51.3
65 and over	35,075	1.8	1,941	.6	3,043	.8	3,662	1.2	4,262	1.6	4,755	2.0	7,903	2.9	6,052	4.8	471	19.6	2,986	40.1
Total (women)	833,637	100.0	321,319	100.0	205,542	100.0	98,062	100.0	79,721	100.0	61,193	100.0	52,996	100.0	13,506	100.0	494	100.0	804	100.0
Under 20	25,201	3.0	25,201	7.8																
20 to 24	129,418	15.5	110,799	34.5	18,619	9.1														
25 to 29	111,476	13.4	60,550	18.8	47,124	22.9	3,802	3.9												
30 to 34	76,893	9.2	30,827	9.6	30,320	14.8	14,137	14.4	1,609	2.0										
35 to 39	74,842	9.0	25,441	7.9	23,764	11.6	14,886	15.2	9,499	11.9	1,252	2.0								
40 to 44	82,929	9.9	22,697	7.1	23,109	11.2	14,346	14.6	13,301	16.7	8,200	13.4	1,276	2.4						
45 to 49	114,051	13.7	20,832	6.5	27,105	13.2	19,158	19.5	18,490	23.2	16,276	26.6	11,752	22.2	447	3.3				
50 to 54	98,352	11.8	13,945	4.3	19,410	9.4	15,182	15.5	15,976	20.0	15,035	24.6	15,231	28.7	3,573	26.5	0	0		
55 to 59	68,326	8.2	7,511	2.3	10,429	5.1	10,061	10.3	11,555	15.4	10,842	17.7	12,714	24.0	4,915	36.4	161	32.6	138	17.1
60 to 64	36,578	4.4	2,733	.9	4,318	2.1	4,582	4.7	6,662	8.4	6,626	10.8	8,132	15.3	3,020	22.4	161	32.6	344	42.9
65 and over	15,571	1.9	792	.2	1,344	.7	1,908	1.9	2,629	3.3	2,962	4.8	3,891	7.4	1,551	11.5	172	34.9	322	40.0

Note: Percentages may not add to totals, due to rounding.

ITEM 5. DEPARTMENT OF AGRICULTURE

FEBRUARY 19, 1973.

DEAR MR. CHAIRMAN: Thank you for your letter of December 15, 1972, to Secretary Butz.

We are enclosing a statement of the Department's major activities during 1972 in providing assistance to the elderly, for your report, "Developments in Aging—1972."

If we can be of any further help to you, please let us know.

Sincerely,

PHILIP C. OLSSON,
Deputy Assistant Secretary.

[Enclosure]

FOOD AND NUTRITION SERVICE

The U.S. Department of Agriculture has two family food assistance programs—the Food Stamp and the Food Distribution programs. They are geared to provide assistance for meals served at home. It is believed that program improvements and outreach efforts of the past year have been particularly interesting and beneficial to the elderly.

PROJECT FIND

In 1972, a major drive was conducted—Project FIND—to seek out the elderly in all 50 States to inform them of these programs, and to encourage those of low income to apply for food assistance.

With the August mailing of Social Security checks, a brochure was included describing these programs. A prepaid return card was also enclosed on which the recipient could indicate interest in receiving more information and assistance in applying for food help. A similar card was also mailed to Civil Service retirees by the Civil Service Commission and the Railroad Retirement Board made an informational mailing to its membership. These mailings reached some 21 million people over 60 years of age.

Nearly 1.5 million cards were returned to the Social Security Administration which, in turn, sorted and mailed them to local American National Red Cross chapters nation-wide for follow-up on an individual basis. The Red Cross agreed to coordinate a massive cooperative effort by many national, State, and community organizations to recruit and train volunteers to make personal contact with those who returned the cards and to help them in every way possible.

On the Federal side, Dr. Arthur Flemming, former Secretary of the Department of Health, Education, and Welfare and Chairman of the 1971 White House Conference on Aging, served as chairman of an inter-agency panel to put to work on this project the resources of Federal agencies such as ACTION, Department of Health, Education, and Welfare, the Office of Economic Opportunity, the Social Security Administration, and the U.S. Department of Agriculture.

Radio and TV spot announcements, organizational newsletters, and thousands of informational fact sheets informed the elderly that food assistance was available for those in need and to urge them to participate.

As a result, voluntary reports received from over three-fourths of the Nation's counties revealed that 156,138 elderly persons had been certified for USDA food assistance during the course of Project FIND. Of this total, 136,621 were certified for the Food Stamp Program and 19,517 for the Food Distribution Program. From a careful analysis of efforts made in the rest of the country, which included many populous areas, it is estimated that the FIND project brought more than 190,000 elderly into a food assistance program.

FOOD STAMP PROGRAM

Under this plan, food stamp coupons are provided for low-income households to spend in retail grocery stores. The very poor receive their coupons free. Other families pay a portion of their income (never more than 30%) and receive an allotment of coupons sufficient to purchase a nutritionally adequate diet.

The 1971 amendments to the Food Stamp Act brought some changes that eased participation by the elderly. A household of two or more with one person over age 60 may have assets of $3,000 instead of the usual $1,500. For those households not receiving public assistance, certification has been simplified so that the applicant may authorize someone to apply for him and the application

may be filed by mail. Although all such households must be interviewed, those who are unable to go to the certification office may be interviewed in a home visit or by telephone.

The disabled elderly may also use their food stamps to pay for meals delivered to their homes by non-profit meal delivery systems. By the end of 1972, there were over 570 such organizations authorized to accept food stamps for home-delivered meals.

Considerable Food Stamp material, which has been translated for specific ethnic groups—Chinese, Spanish, Jewish (Yiddish), Finnish—has proven to be most helpful to senior citizens. Included are brochures, fact sheets, posters, and radio spot announcements. Local agencies and organizations have also translated some materials into other languages, such as, Navajo, Japanese and Ilocano (a Filipino dialect).

Food Distribution Program

This program makes donated foods available to low-income families in about a fourth of the Nation's counties. This is essentially all counties not served by the Food Stamp Program. More than 20 foods are provided. Family distribution guides have recently been revised to permit greater flexibility at the local level and to conform with local food consumption habits and nutritional needs. This change is expected to benefit households of elderly persons, since it encourages distribution centers to make the foods available each month in small container sizes wherever possible.

The Drive to Serve Program, initiated in April of 1971, is expanding. It is designed to meet needs of the elderly or handicapped who are eligible for donated food, but are unable to travel to the distribution center to pick up their commodities. This program sets up a delivery system which utilizes the services of such national organizations as the American Red Cross, Future Farmers of America, and others, and also students in driver education classes. The National Jaycees have established the goal of initiating Drive to Serve programs as one of their priority projects. Special recipe booklets geared to households of one or two people with particular appeal to the elderly have been made available for use in the Drive to Serve Program as well as for other elderly recipients in counties which distribute the USDA-donated foods.

All labels for family-sized packages of USDA donated foods have been redesigned to increase the utilization of these foods by recipients with an eye especially toward the elderly, and to improve the attractiveness of the donated foods. Food use suggestions, storage hints, information in Spanish, plus designs in two colors are some aspects of the new labels. Illustrations on all front panels depict the enclosed food or types of dishes that can be made from the packaged contents. This, too, is proving helpful to the elderly.

In addition to food help given to needy families, selected foods also are made available to public and private non-profit institutions, senior centers, and other charitable organizations. A survey of the institutional program, now nearing completion, will help USDA evaluate recommendations for improving the program's effectiveness to the elderly as well as other groups being served.

Many organizations are now providing home-delivered meals to elderly shut-ins, and handicapped people. These "Meals-on-Wheels" programs may receive USDA donated foods to the extent of the needy persons they serve.

USDA also makes Operating Expense Funds available to State distributing agencies to assist them in meeting expenses incurred in operating food distribution programs for low-income households. Some communities have used these funds to assist the elderly in ways such as: the purchase of shopping carts to help elderly recipients with food packages; the purchase of trucks for mobile and satellite distribution points to make the food more accessible, and for general improvement of distribution centers to make them more convenient.

In Puerto Rico, an orderly expansion of the donated foods program is in progress. It will include all low-income households having a resident member 55 years of age or older.

1973 Follow-Up

In 1973, the U.S. Department of Agriculture expects to build on the momentum engendered by Project FIND. The 1971 amendments to the Food Stamp Act mandated outreach by the State agencies administering the program and the State plans submitted for outreach place high priority on reaching the elderly. Project FIND provided an excellent base from which the States can meet this priority.

A pocket-size leaflet, "Food Aid for the Elderly" (FNS–81) issued the past year, will continue to be available for outreach purposes.

The Food and Nutrition Service also is developing a publication for use by one- and two-person households participating in the Food Stamp and Food Distribution Programs. "Cooking for Two" will be particularly useful to elderly persons who reside alone or with one other family member. In addition to recipes in two-serving sizes, this publication will contain information on nutrition, menu ideas, and helpful hints on planning and serving meals. It should be available by early summer of 1973.

FARMERS HOME ADMINISTRATION

The Farmers Home Administration is a rural credit agency. It administers more than a score of credit programs through 1,750 local and 42 State offices.

Farmer Programs

A total of $567 million in initial loans for the purchase, development and operation of farms were made during Fiscal Year 1972. Subsequent loans for the same period amounted to $234 million. In addition, $298 million was made available through participation lending with other creditors, More than $5 million, or 1 percent, went to borrowers who were over 65 years of age, Eleven percent went to borrowers aged 45 to 65. Although statistics on the amount of subsequent funds going to elderly people are not available, experience leads FHA to believe that a larger percentage went to the elderly than in the case of initial funds.

Housing

Initial loans for housing programs in Fiscal Year 1972 totalled over $1.6 billion. Of this, more than $56 million or 3.5 percent was loaned to elderly citizens.

Community Programs

Some 1,200 communities were able to install or improve water or waste disposal systems, or both, with aid from the Department amounting to $300 million in loans and $40 million in grants during Fiscal Year 1972. Another $2 million in grants was provided to assist State and local agencies to develop comprehensive water and sewer plans in rural areas. In addition, $16 million in loans was made to local public bodies and non-profit organizations in rural areas for watershed development, resource conservation and development projects, improved grazing facilities, and irrigation and drainage projects. These programs are designed to enable local people to plan, develop, utilize and maintain land, water, air and related resources essential for the continued development of prosperous rural communities. They also promote and support environmental conditions favorable to desirable ecological systems.

The development and improvement of these essential community facilities and services benefit rural residents of all ages. The advantages of adequate supplies of clean water piped into houses, along with the convenience of sanitary sewage facilities piping liquid wastes out of homes are of special benefits to the aging and elderly of these many rural communities. They also enjoy economic and social benefits and advantages from better conservation, utilization and management of land, water and related resources afforded by loans for these community facilities projects.

EXTENSION SERVICE

The Extension Service considers the elderly an important part of its overall educational responsibility. As this segment of the population has increased, Extension programs have been strengthened and will continue to grow.

Extension programs for the aging concentrate on helping with problems such as limited income, health, nutrition, housing, and inadequate knowledge of community resources. Extension educators hold open meetings, train leaders for leader-conducted classes, send newsletters, use mass media, and other methods to reach their audience.

Increasingly, many States are employing State specialists to give leadership to programs for the elderly. Arkansas, Texas, Oregon, North Carolina, Nebraska, New Hampshire, and Vermont already have such specialists on their staffs. States like Virginia, Louisiana, and Missouri are designating the aging as a special assignment for State staff members.

The over 650,000 member Extension Service—related National Homemakers Council also is directing programs to the elderly audience. These homemakers meet in clubs or study groups. Their work is supported by Extension home economists. Approximately 17 percent of the Extension Homemaker Club members are 65 or older.

Mass media has proven an effective way of teaching the elderly with educational information. Extension State and county news releases are sent out across the country. Radio and TV programs are aired. In West Virginia, for example, the Extension Service works with the West Virginia Commission on Aging and WMUL–TV to produce "Living," a TV series for the elderly. Twelve color half-hour shows were aired in 1972. Mountain heritage crafts were demonstrated, along with wood carving, quilting, weaving and spinning. Extension educators provided information on consumer problems, health and meal planning.

Health

Through meetings, classes, newsletters, publications and mass media, Extension educators direct information on health to senior citizens. They also cooperate with other health-related agencies.

In West Virginia, the Extension Service assisted the Upshur County Senior Citizens Council to set up a series of flu clinics for people 55 years of age and older. Vaccinations were given at cost, or free, if there was need.

A North Carolina Extension home economist developed a demonstration kit of ideas to help elderly and handicapped homemakers perform grooming skills and routine kitchen chores. Among the items included were aids for wheelchair patients and a "bed assist"—a simple gadget that helps patients move themselves about in bed. An illustrated handout piece was developed to give to people interested in making the aids. The demonstration kit and similar kits of ideas have been shown in more than 75 percent of North Carolina counties.

Many States have developed special teaching materials for the elderly audience. "Emotional Health in the Senior Years" is the title of a publication prepared by Kentucky Extension specialists. "Let's Think About Aging" is another one.

Money Management

Many citizens, living on fixed incomes, find it extremely difficult to manage their money and live comfortably without financial stress. The Extension Service seeks to provide assistance.

In Arkansas, for example, a series of meetings were held to help pre-retirement and post-retirement families learn to get the most out of their financial resources. Investments were discussed, as were wills and the dangers of fraudulent schemes which destroy the savings of the unwary.

Consumer aides, selected from the elderly audience, are extending information to the rural elderly in Vermont. In 1972, more than a thousand families were reached through the efforts of 17 aides. The aides carry information about USDA's Food Stamp Program, Medicaid, Old Age Assistance and other programs of interest. They also advise in the areas of nutrition, safety, health, etc.

Nutrition

With fixed incomes and an inadequate knowledge of good nutrition practices, many older Americans are not getting the nourishment they need. Extension educators direct special programs to the elderly to help them improve their diets.

Through its Expanded Food and Nutrition Education Program (EFNEP), Extension Service has employed aides to teach low-income hard-to-reach homemakers and youth how to improve their diets, stretch their food dollars and utilize resources.

Twenty-one percent of the aides (low-income homemakers themselves) are 50 years of age or older. A sample survey of 10,000 families showed that 30 percent of those reached through the program were 50 years of age or older. Approximately 10,000 Extension aides have extended information to more than 3 million low-income families since EFNEP began in November 1968. In Pennsylvania, Schuylkill County, EFNEP aides and Extension home economists work closely with 17 senior citizen organizations to improve diets.

Nutrition newsletters are used by many Extension specialists and home economists to communicate with senior citizens. In New Jersey, for example, the Gloucester County Extension home economist sends out a newsletter titled "With You in Mind" featuring tips on meal planning, nutrition and food shopping.

To promote good nutrition among the elderly, Extension home economists work cooperatively with other organizations and agencies. For example, in Lycoming County, Pennsylvania, the home economist serves as consultant to the local nutrition Committee. A Meals on Wheels Program serving 110 senior citizens is one of their projects.

Older men and women in three Minnesota high-rise apartment buildings participated in a series of Extension classes on food buying. Many Minnesota organizations of senior citizens have had special training meetings on good nutrition and food for fitness.

An Extension home economist in Massachusetts developed a program for occupants of a high-rise for handicapped people of all ages. About 63 percent of the occupants attended. Program consisted of informal talks on basic nutrition, psychology of living and eating alone, food buying for one, food preparation and storage, food faddism.

"Cooking For One or Two As We Grow Older" was the topic of a short course given senior citizens in Nebraska. Most sessions were held in public housing units.

Volunteer Service

Recognizing the talents and abilities of many older people, the Extension Service encourages the elderly to participate in Extension programs as volunteer leaders. In Arizona, for example, a group of senior citizens sponsored a 4-H club for the children of migrants.

In New York, RSVP (Retired Senior Volunteer Program) funded by ACTION operates through the Extension Service in Madison County. Senior citizens work as volunteers at local hospitals, visiting with patients, writing letters for them, reading to them, etc. Some of their work is with elderly people like themselves; other work is done with children. As a result of the success of this work, volunteers have been requested to tutor children on a one-to-one basis, visit isolated older persons on public assistance, help to rapair library books, and assist the local Meals on Wheels Program.

Community Development

Extension helps communities adapt to the needs of senior citizens. It supports the elderly in their efforts to organize for constructive purposes. Extension also has been able to aid senior citizens in finding ways to supplement their incomes.

Extension specialists in Missouri saw the need to provide mobility for many senior citizens living in rural communities. A cooperative busing program providing scheduled bus service to rural communities on specified days was set up on a trial basis. Designed to be self-supporting, the system charges a minimum fare and provides service to nearby city, medical and shopping facilities. The cooperative now owns eight buses and serves 15 counties and 2,329 senior citizens.

Many Extension specialists and home economists are helping senior citizens organize groups to meet together, discuss mutual concerns and problems and work toward individual and community betterment. In New Jersey, an Extension home economist was responsible for the formation of the Gloucester County Senior Citizens Organization. Because of the interest generated by the home economist, a new office of the New Jersey Division of Aging was opened.

In Hand County, South Dakota, the Extension home economist also played an important part in establishing a senior citizens group. The newly-formed organization then went on to set up a senior citizens meeting place for craft classes, suppers and educational meetings.

In many States, Extension educators are encouraging senior citizens to share their skill in crafts with others. Demonstrations, hobby and art shows and other events are set up. In Iowa, for example, 74 senior citizens were selected to explain their crafts to the more than 2,000 people who attended a four-county arts and hobby show. In some States, opportunities are provided for elderly people to sell their crafts, thus bringing in some welcome income.

Housing

Nearly all States have Extension specialists assigned to work in the area of housing. Increasingly, these specialists are allocating some of their efforts to work with the elderly audience. New York State has hired a specialist to concentrate on social and physical environments for the elderly. Several States have home-making rehabilitation specialists on their staffs. They, too, are working with the elderly.

Oregon and Florida Extension specialists, and other State specialists as well, have produced special housing plans for the elderly. Special features such as wider steps, grab bars in the showers, etc. are featured.

New high-rise apartment buildings were built for senior citizens in Tompkins County, New York. Extension Service staff, working with the local Senior Citizen Council, formed a housing education committee. This group developed a directory of helpful ideas for the elderly. In the publication, titled "Moving," were listed the names and addresses of people who would buy, appraise, or move possesions. Also listed were the names of people who could counsel on business, health and housing problems. Free counseling services were provided at the Senior Citizens Center. A list of "Questions to Ask Before Moving" was given out as a handout.

Many older residents in Maysel, Clay County, West Virginia, will soon be enjoying new homes, thanks to the efforts of the West Virginia Commission on Aging and the Clay County Extension Agent. Funds were received to develop small rental housing projects. The county Extension agent helped to organize community support for the project, assisting in setting up a non-profit corporation and getting loans from FHA.

AGRICULTURE

The Midwest Plan Service, a cooperative effort of all Midwest State agricultural engineers, is developing plans for farm facilities such as chicken coops, housing for farrowing sows, etc., that will be especially useful and practical for older low-income farmers. The facilities are designed to increase farm income and get a better return on labor.

Extension specialists and county agents in North Carolina are helping to promote the hand-picked cucumber industry for aging, low-income farmers. In 1972, 77 small farmers grossed $30,000 from this program.

The Texas Extension Service has a pilot project in 10 counties employing male program aides to contact aging, low-income farmers and inform them of their eligibility for USDA food stamps, ASCS cost sharing programs, FHA loan programs, water systems, etc. They also advise on money management and increasing farm income.

ITEM 6. DEPARTMENT OF COMMERCE

JANUARY 31, 1973.

DEAR MR. CHAIRMAN: This is in further response to your request of December 15, 1972, for information concerning the activities of the Department of Commerce relating to older Americans.

The historic mission of the Department of Commerce is "to foster, promote, and develop the foreign and domestic commerce" of the United States. This has evolved, as a result of legislative and administrative additions, to encompass broadly the responsibility to foster, serve, and promote the nation's economic development and technological advancement.

Accordingly, the Department's activities during the past year were generally designed to further the national economic goal of sustained maximum growth in a free market economy, without inflation, under conditions of full employment and equal opportunity. Rather than benefiting or promoting the interests of any particular segment of the population, such as the aging, these activities and programs serve the American people as a whole.

Several areas in which we have worked are, however, of special relevance to older Americans. The Department, through the National Bureau of Standards (NBS), is trying to impove building technology for the benefit both of the construction industry and the ultimate user. NBS is also working toward a standardization of building codes. Both of these efforts are designed to reduce the cost of housing, which will be of benefit to the elderly as well as to all citizens.

During 1972, NBS was also specifically concerned with building codes and standards in construction of nursing homes for the elderly, and undertook, pursuant to a contract with HEW, to begin a study of ways to impove the quality of these homes. Further, in conjunction with a HUD program to develop housing prototypes, Operation Breakthrough, NBS has prepared guide criteria which contain specific reference to design features for the elderly.

Since fires are an especially serious hazard for older people, the flammability standards which have been issued by NBS are of special import to the elderly. In June 1972, flammability standards for matresses were issued, joining previously issued standards for certain other interior furnishings such as carpets and rugs.

In the future, it is expected that similar flammability standards will be issued for additional items of home furnishings.

During the past year, the Department has continued to work with the Departments of Labor and Treasury and the Social Security Administration in a joint effort to develop proposals that would give greater assurance that workers actually receive the benefits which are provided for in private pension plans. We expect to continue our work in this area, and plan to review proposals which would, *inter alia*, require pension benefits as a condition of employment, assure employees a greater voice in the management of their pension plans, and permit greater portability of pension benefits so that an employee would not lose his accumulated benefits if he changed jobs. All of these proposals involve substantial technical difficulties which must be resolved before any firm recommendations can be made. The Department's participation in this effort is geared to finding constructive solutions to these technical problems. Without such solutions, the imposition of any Federal requirements with respect to pension plans could operate to the detriment of employees by causing their employers to abandon or minimize the benefits of existing plans or by discouraging the adoption of pension plans where none now exist.

Finally, the National Business Council for Consumer Affairs (NBCCA), which is a Presidential advisory committee composed of key business executives reporting through the Secretary of Commerce, has recently made several recommendations which are particularly significant to the elderly, who are often the first to be victimized by fraudulent, misleading, or unfair consumer practices. For example, the NBCCA has recommended voluntary nutrient labeling by manufacturers or processed food products. Further, it has recommended that businesses voluntarily provide unit price information for consumer products on their packages or labels. Such information is of great value to older people who generally have a limited income and who must choose wisely from a wide variety of food and household products.

In addition, the NBCCA has urged advertisers to give special consideration to eliminating confusion when communicating advertising claims to special audiences, such as the elderly, who may be especially vulnerable to certain types of claims. It has also made several recommendations relating to credit criteria in recognition of the fact that the problems of credit availability can be significant for lower income individuals, since credit often provides them with the only means for obtaining necessary consumer goods.

Thus, although the Department's programs are not designed to serve the elderly directly, several of our activities do have a significant impact upon their well-being. Perhaps most important is the fact that the Department's continuing efforts to strengthen the economy of our nation helps to provide all of our citizens with the opportunity for steady employment and income and a chance to build up resources for their older years.

Sincerely,

PETER G. PETERSON,
Secretary of Commerce.

ITEM 7. DEPARTMENT OF DEFENSE

FEBRUARY 15, 1973.

DEAR MR. CHAIRMAN: This is in reply to your letter of December 15, 1972, requesting information summarizing the Defense Department's major activities for older Americans for inclusion in an annual report on Developments in Aging—1972.

During the year the Department of Defense developed and implemented a comprehensive retirement planning program for civilian personnel of the Department. The program was established as an integral part of the over-all personnel management process and has the primary objectives of (1) assisting employees in their adjustment to retirement, and (2) assisting management in planning for replacement manpower needs. The program is designed to provide employees with a personally adequate understanding of retirement benefits and to convey to them a genuine concern for their social and economic well-being at the conclusion of their careers.

Under the Defense program, each of the military departments and defense agencies develops a retirement planning program for its own employees based on the needs of its employees and the capabilities of the organization to integrate

planned retirement into its manpower planning. The scope of their programs is not limited to the customary pre-retirement counseling, but includes such features as trial retirement and gradual retirement options for interested employees.

Pre-retirement counseling seeks to advise employees of the full range of retirement benefits available to them, and to apprise them of the many and varied subjects that need to be considered in order to properly prepare for retirement. Trial retirement options entail mutually agreeable plans by which employees who are eligible for optional retirement are permitted to try retirement for a given period of time with the option of returning to work if they so desire. Under gradual retirement options, employees either retire optionally with immediate reemployment for less than full-time duty, or their employment is phased down through a mutually agreeable plan of less time on the job or less demanding duties.

Further developments with regard to retirement include: (1) an innovative study being conducted at a Naval installation aimed at expanding career counseling to include life-planning—looking toward a "life cycle" concept which, at an early stage, will enable the employee to envision and plan for retirement as one phase of the individual's total life program; and (2) the Phoenix Society established in the National Security Agency as a social club designed to furnish greater educational, social, humanitarian and recreational services to Agency civilian retirees and prospective retirees.

The Department of Defense actively cooperates with ACTION, the new Federal agency that combines several citizen service programs into a unified effort devoted to helping people help themselves. Through membership on ACTION's Interagency Coordinating and Liaison Committee for Federal Employee Voluntarism, we assisted in developing and intiating a campaign to encourage greater Federal employee participation in community volunteer activities involving the contribution of time, talents and energies off the job. Many of these activities, of course, involve services and assistance to older Americans. We have publicized the promotion of Federal Employee Voluntarism throughout the Department of Defense and encouraged active participation by all employees in this effort.

Many of the components of Defense conduct health and placement programs which are designed to provide maximum practicable assistance to employees who have limitations resulting from physical and mental disabilities, including limitations resulting from increasing age. An example of special health programs is the one conducted during 1972 for employees of the Office of the Secretary of Defense which included glaucoma screening, electrocardiogram testing, diabetes screening and blood pressure check free of charge to employees over age 40.

As a result of the President's memorandum of September 13, 1972, reaffirming our commitment to the Federal Government's long-standing policy prohibiting discrimination on the basis of age, a review of employment practices throughout the Department was undertaken to insure that no artificial barriers existed to full equal employment opportunity for older American citizens.

Department of Defense plans for follow-up efforts during 1973 will remain essentially the same as in 1972, with emphasis on program improvements and augmentation.

It is hoped that the above information will be helpful to you.

Sincerely,

CARL W. CLEWLOW,
Deputy Assistant Secretary of Defense

ITEM 8. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

MARCH 27, 1973.

DEAR MR. CHAIRMAN: I am pleased to provide a statement summarizing the Department s major activities for older Americans, as well as follow-up efforts during 1973.

One major follow-up effort to the Department's evaluations was identified by the President in his recent State of the Union Message on Human Resources. The President noted that two-thirds of the 20 million persons 65 and over own their own homes. A disproportionate amount of their fixed income must now be used for property taxes. The President announced that he will submit recommendations to the Congress for alleviating the often crushing burdens which property taxes place upon many older Americans.

I would like to assure the Committee of my Department's continuing dedication to serving the needs of our older Americans. I look forward to our future associations in this regard.

Sincerely yours,

JAMES T. LYNN.

[Enclosure]

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

I. OVERVIEW—1972

In his "Recommendations for Action on Behalf of Older Americans," President Richard Nixon stated: "It is my conviction that the complex interwoven problems of older Americans demand, above all else, a comprehensive response, one which attacks on a variety of fronts and meets a variety of problems." He further stated the goal:

"By establishing overall objectives and by providing both money and mechanisms for a stronger planning and coordination effort, we can ensure that resources and energies which are now widely scattered and fragmented can be pulled together in ways which will notably increase their impact."

To achieve the President's goals, the Department has given new emphasis to the elderly in all programs.

On March 27, 1972, former Secretary George Romney announced the appointment of an Assistant to the Secretary for Programs for the Elderly and the Handicapped and stated his intent to ensure that HUD programs would be fully responsive to the needs of the elderly and the handicapped.

Internal organization for this new emphasis became the first requirement. As principal advisor to the Secretary, the Assistant to the Secretary was assigned the appropriate functional responsibilities, including coordination of matters involving the elderly and the handicapped. This action permitted the addition of an office responsible directly to the Secretary for the fulfillment of the new emphasis, without disrupting or duplicating the existing functional responsibilities assigned to the Assistant Secretaries. All Assistant Secretaries retain their previously-assigned responsibilities but now fulfill the additional requirement of coordinating with the Assistant to the Secretary, Programs for the Elderly and the Handicapped, in the administration of such activities affecting the elderly.

To facilitate coordination, Central Office program level liaison personnel were designated by each Assistant Secretary. Referred to as specialists in programs for the elderly and the handicapped, these program experts were later designated to also serve as technical consultants to the regional and field specialists.

Regional specialists in housing management, housing production, community development, and community planning and management have now been established. They serve as advisors to their respective superiors, to state and regional interests, both public and private, and to other HUD field specialists within their respective regions.

Area and Insuring Offices have also designated specialists to serve in direct support of the field office directors in the processing of applications submitted to their respective offices and in assisting communities and sponsors of programs for the elderly.

While these actions took advantage of available and interested experts in various HUD programs, it was acknowledged that basic service for the elderly and the handicapped are dependent upon the full utilization of all available resources. Thus, the establishment of coordinative working relationships with public and private sector agencies at local, state and regional levels became the primary objective in traning the specialists. Consistent with another effort initiated concurrently by the Secretary, the additional objectives of quality production and improved consumer orientation were also adopted.

In training the specialists, the first Departmental effort was conducted in July 1972, in Washington, D.C. All regional specialists in housing management and production participated in a three day conference. The keynote address was given by former Secretary Romney and presentations were made by John B. Martin, Special Consultant to the President and Commissioner on Aging (HEW), and Edward Newman, Commissioner of the Rehabilitation Services Administration, and spokesmen for the National Council on Aging, the American Association for Retired Persons, the National Retired Teachers Association, the American Association of Homes for the Aging, the National Assocation of Retired Federal

Employees, the Gerontological Society and several other program directors in the Administration on Aging and the Social and Rehabilitation Service of HEW.

Since the Washington training conference, regional level training conferences also have been completed in Seattle, San Francisco, Dallas, Boston, and New York. Following the concept of the national conference, public and private sector agencies have also participated in the regional efforts. Numerous continuing relationships are progressing between such agencies as a result of these conferences.

At the national and state levels, several inter-agency activities and agreements have been initiated to enhance the delivery of services to the elderly, and a selected mailing of current HUD information releases has been instituted for national associations supporting the elderly and the handicapped.

Specific results of effective coordination will be presented throughout the report. Following are a few of the longterm activities formulated during the year:

1. Increased cooperation between HUD's Nursing Home Branch and other Federal agencies, including the Small Business Administration, and new emphasis on partnerships between HUD and state agencies and boards as well as voluntary trade and professional organizations.

2. Along with other Federal agencies, HUD participated in a Health Services for the Elderly seminar in November under the auspices of the Health Services Delivery section of HEW.

3. Criteria and guides on housing for the handicapped, including design considerations and services, are currently being discussed with the Rehabilitation Services Administration, HEW.

4. HUD has participated throughout the year in conferences on developmental disabilities to explore the potentials of residential environments for these segments of the population through use of HUD programs. A review of programs was prepared by HUD for use by agencies and organizations interested in providing a normal housing setting as opposed to institutions for handicapped persons. Research studies have been funded by HUD and others have been proposed which will provide greater understanding of the needs and housing solutions for the handicapped. A description of these studies and their status will be found in Section VII, Research and Technology.

5. HUD participates regularly with the President's Committee on Employment of the Handicapped, Committee on Barrier Free Design, in its development of efforts to give the handicapped freedom of association in man's "built-environment."

6. In addition to joint research efforts with the Social and Rehabilitation Service, HUD is working with the recently established Technical Advisory Committee on Research for the Aging (HEW) to ensure concerted, complementary development of research programs.

The Department also worked closely during the year with Arthur Flemming, the President s Special Consultant on Aging, in the review of recommendations submitted by the 1971 White House Conference on Aging. Specific responses to those recommendations will be the subject of a forthcoming Administration report to the Congress.

HUD actions affecting the elderly during 1972, and described in this report, were of course carried out under, and are subject to the limitations of, the individual programs which the Department was administering that year. In the case of subsidized housing, these programs have experienced numerous problems and involve approaches which have given rise to many issues of equity, effectiveness and cost. Accordingly, as announced by former Secretary Romney on January 8, 1973, the subsidized housing programs have now been suspended and the Administration is reviewing the deficiencies of these programs and evaluating alternative approaches for meeting the housing needs of our citizens, including the elderly. During this review, the Federal Government will continue to honor commitments already made, and the level of HUD subsidized housing starts during calendar year 1973 is expected to be at about the same level as in calendar year 1972.

Also, the HUD community development programs which in the past have supported projects of interest to the elderly—notably the Neighborhood Facilities Program—are being terminated and will be replaced under a proposed Better Communities Act with a new system of community development revenue sharing. Under this program, communities will be able to carry out all the types of activities previously authorized under the categorical programs, but they could secure funds far more quickly, without Federal red tape or matching requirements, and

could use those funds more flexibly in providing a broad range of facilities, including centers for senior citizens. During the transition period, the Federal Government will continue to honor commitments already made and activity out of undisbursed obligated balances is expected to remain at least equal to cost in 1972.

II. Program Evaluation

Actions were begun in 1972 to develop basic data relating to elderly housing needs and the collection of more comprehensive age data in the course of HUD program operations. HUD has contracted with the Bureau of Census for data by age, income, housing standards, race, geographic location and other definitions. These data, when cross-tabulated, will provide a national profile of the elderly.

All HUD statistical reporting forms have been reviewed in order to improve the collection of data by age of consumer. Age reporting in all programs of significance for the elderly has increased in 1972 and will continue in 1973 until complete coverage is achieved.

A recapitulation of existing HUD housing projects for the elderly is also being developed.

These efforts should provide opportunities for improvements in evaluation and design of future programs.

III. Housing Production and Design

A. HOUSING PRODUCTION

Major emphasis in 1972 was given to the improved quality of the living environment for the elderly and handicapped. At the same time, the production of specially designed housing for the elderly exceeded expectations with 70,385 units being authorized in FY 1972, an increase over the 66,000 units estimated in the President's March 23, 1972, Message on Aging. The cumulative total of "specially designed" dwellings approved for construction for the elderly through December 31, 1972, is 452,414.

Detailed data on production of subsidized and unsubsidized housing for the elderly and the handicapped are provided in the following table:

MULTIFAMILY HOUSING FOR THE ELDERLY AS OF DEC. 31, 1972

[Calendar years]

Program	Units approved					Units under management (calendar year)				
	1969	1970	1971	1972	Total (all years)	1969	1970	1971	1972	Total (all years)
Subsidized:										
Sec. 202	2,546	398	391	-------	45,494	5,278	6,778	6,092	2,006	44,322
Sec. 221(d)(3) [1]	-------	-------	-------	8,900	8,900	-------	-------	-------	-------	-------
Sec. 236 [3]	-------	-------	-------	21,832	21,832	-------	-------	-------	-------	-------
Sec. 202/236 [2]	660	12,936	8,208	5,684	27,448	-------	1,849	1,248	9,172	12,269
Low rent public housing	36,712	41,469	33,321	33,969	348,730	32,366	37,470	43,929	24,767	313,555
Total	39,918	54,803	41,920	70,385	452,414	37,644	46,097	51,269	35,945	370,146
Unsubsidized: Sec. 207 and 231 Elderly	-------	190	190	775	49,053	1,342	1,340	180	30	40,999

[1] Incomplete. Information based on estimates of fiscal year 1972 approvals only.
[2] Sec. 202 conversions to Sec. 236 only. Based on firm commitments issued.
[3] Incomplete. Sec. 236 elderly were not identified in production data until fiscal year 1972. Figures shown are fiscal year 1972 approvals only.

Note.—All 1972 figures are preliminary (resulting in preliminary totals).

1. Unsubsidized Multi-Family Rentals

HUD's major program for the development of unsubsidized rental housing for the elderly is the Section 231 mortgage insurance program. Under this program, HUD-FHA is authorized to insure lenders against losses on mortgages for construction or rehabilitation of rental housing for the elderly and handicapped.

Although Section 231 is intended primarily for the unsubsidized market, nonprofit sponsors of projects developed under this program have also been eligible for participation in the rent supplement program. Section 231 provides mortgage insurance for up to 90 percent of replacement cost in the case of profit-motivated sponsors and up to 100 percent of replacement cost for nonprofit sponsors. Mortgage terms may be for as long as 40 years. The current maximum interest rate is seven percent, plus one-half of one percent mortgage insurance premium.

In 1972, the Section 231 program attracted a modest increase in interest among sponsors as compared to 1971. Further increased interest and activity, after some years of decline, appear in prospect for Section 231. This may occur both with respect to housing for the elderly and handicapped who can live fully independently, as well as those who would benefit from modest assistance available in congregate housing, now also eligible for development under the unsubsidized Section 221(d)(3) market rate program without rent supplements and also under the Section 221(d)(4) program, both of which are intended for those in the moderate income group.

2. Homeownership

HUD is concerned with the severe problems facing many elderly homeowners. About 70 percent of all elderly live in owner-occupied homes and over 80 percent of their homes are owned mortgage free. Many of these owners can become "house poor," because property taxes (see CPM Section VI) and other housing costs are generally rising faster than incomes. Moreover, many homes owned by the elderly were built for younger and larger families, and as a result, they impose a severe financial and maintenance burden. It is believed that many older people would like to move out of these homes into new, smaller, more appropriately designed units, but rising rental and purchase costs often deny them such opportunities.

3. Direct Subsidy Housing

As indicated in the overview statement at the beginning of this report, many problems and issues of equity, effectiveness and costs have arisen in connection with the operation of the HUD subsidized housing programs. Thus, these programs were suspended early in calendar 1973 and a review and evaluation launched covering program deficiencies and alternative ways of helping those who require assistance in meeting housing needs. As also indicated in the overview statement, commitments already made will be honored while the review is going on, and it is anticipated that the level of HUD subsidized housing starts during calendar year 1973 will be about the same as in calendar year 1972.

Prior to the suspension of the subsidized housing programs, the Department had taken a number of steps in an effort to improve the performance of those programs as they related to the needs of the elderly. These steps, as well as others, will be closely reviewed in the evaluation of the Federal government's housing program.

a. Unit Allocations

Under the subsidized multi-family programs, the allocation of fiscal year 1973 housing production funds to each field office was based upon 1970 census data on the distribution of the elderly population. Consistent with this action, the previous policy of allocating to the elderly no more than ⅓ of the contract authority for low rent public housing units, in any locality, was changed. Such units are now allocated by HUD Area offices on the basis of local needs for the elderly versus other categories. (For reasons related in the Overview statement, HUD subsidized housing programs, including the Section 236 and public housing programs, were suspended in early 1973.)

b. Congregate Housing

The 1970 Housing Act provided for congregate housing under Section 236, Section 221 and low rent public housing, to provide housing more particularly needed by those older people, the handicapped, and displacees who require food and other supportive services. Congregate housing offers a possible deterrent to unnecessary or premature institutionalization.

Over the past year, HUD has issued, in March 1972, a circular (HPMC-FHA 4442.20) implementing the Section 236 and Rent Supplement congregate housing programs, and a more detailed handbook on management of congregate housing (HM G 7460.1) was issued on July 12, 1972.

An incomplete listing of congregate facilities authorized since the 1970 Housing Act follows:

CONGREGATE HOUSING APPROVED SINCE HOUSING AND URBAN DEVELOPMENT ACT OF 1970[1]

Location	Name	Sponsor	Units	Program
Denver, Colo	Sunset Park	Volunteers of America	242	236.
Wilmington, Del	Ingleside Church Home	Church Home Foundation, Inc	208	236.
Atlanta, Ga	Budd Terrace	Budd Terrace, Inc	192	236.
Kalamazoo, Mich	Heritage Hills	Senior Citizens Foundation	172	236.
St. Louis, Mo	University House		201	Low-rent.
Pitman, N.J	Methodist Home in Pitman	Methodist Homes of New Jersey	242	236.
Ithaca, N.Y	Ithacare, Inc	Ithacare, Inc	72	236.
Durham, N.C		Housing Authority of the City of Durham.	283	Low-rent.
Lidgerwood, N. Dak	Dakota Estates	Dakota Estates, Inc	41	221(d)(3).
Milford, Ohio	S. E. M. Villa	Southeastern Ecumenical Ministry.	158	236.
Memphis, Tenn	Wesley Highland Towers	Wesley Housing Corp. of Memphis.	395	236.
Fort Worth, Tex	Salvation Army	Salvation Army	168	221(d)(3).
Arlington, Va	Culpepper House	Arlington Retirement Housing Housing.	203	236.
Madison County, Miss		Regional Housing Authority No. VI.	150	Low-rent.
Alcorn County, Miss		Tennessee Valley Regional Housing Authority.	50	Do.
Santa Rosa, Calif	Salvation Army, Santa Rosa	Salvation Army	216	236.
San Francisco, Calif	Olympic Hotel	Maisin Development Co	180	221(d)(3).
Do	Roosevelt	Apollo Investment Co	151	221(d)(3).
Do	Ramona Hotel	Maisin Development Co	120	221(d)(3).
Do	Manor Plaza Hotel	Applied Urbanology	69	221(d)(3).
Do	Antonia Manor	Maisin Development Co	135	221(d)(3).
Do	Crescent Manor	Pacific National Equity	92	221(d)(3).
Fresno, Calif	Matsen Towers	Catholic Charities	202	236.
Visalia, Calif	The Meadows	Visalia Senior Housing	98	236.

[1] This listing only includes projects under programs effected by secs. 115 and 207 of the Housing and Urban Development Act of 1970. In addition, there are those meeting the statutory definition of congregate housing under other programs, as well as many projects having central dining rooms in addition to full housekeeping units.

B. NURSING AND INTERMEDIATE CARE FACILITIES

In the Section 232 Program, HUD provides mortgage insurance for the construction or improvement of long-term care facilities. These may be nursing homes as well as other facilities for supervised living environment, continuous care, or the rehabilitation of alcoholics, mental retardees, drug addicts, and the physically handicapped by or under the direction of professional or licensed personnel.

As of October 31, 1972, HUD-FHA had insured a total of 934 long-term care projects consisting of 98,436 beds, for a total of $827,162,405 in mortgage coverage. Of these, 96 projects (11,683 beds) were improvements and additions to existing facilities.

There has been recent increased emphasis on alternatives to institutional care for the elderly and handicapped not required by physical, emotional or mental condition to reside within a facility. In support of this concept, HUD has recommended that sponsors include in their long-term care facility planning and development, provision for making available to the elderly and handicapped in the community on an "outreach" basis, the specialized services provided for the residents of the facility. These may include special dietary meals (either in the dining room or delivered to homes as in the "Meals on Wheels" program in many communities); outpatient mental, physical or occupational therapy; group activities; outpatient (community) health and medical care; and other rehabilitation programs. This kind of program cannot only offset operating costs, but can also provide needed services to individuals in the community living on fixed incomes at a lower cost than if those services were developed independently to meet this need.

Several intermediate care facilities are being developed in combination with the Section 23 Leased Housing Program. Upon completion, the care facility is leased to the local housing authority. The housing portion of the facility is financed under the authority of HUD leased housing programs while the services are paid for by the residents.

Inquiries from sponsors indicated an interest in developing "campus" projects offering a combination of independent living and institutional care and services in proximity to each other. In March 1972, HUD authorized an increase in the maximum Section 232 amortization term from 20 to 40 pears. This compatibility of amortization term with that of other HUD mortgage insurance and subsidy programs now permits the simultaneous packaging of Section 231 or 236 projects with Section 232 projects.

With the anticipated continuing increases in the elderly population in coming years, the HUD Section 232 program will support the President's determination to meet the increasing demand for quality health care provided by the long-term care facility.

The HUD Handbook on Administrative Procedures for Nursing Homes and Intermediate Care Facilities were published in 1971 and 1972 respectively.

C. MINIMUM PROPERTY STANDARDS

During 1972, HUD reviewed the minimum property standard for all categories of housing, care facilities and other construction insured by the FHA. Three new volumes will soon be published to consolidate all of the previous publications. These publications have been publicly reviewed and many suggestions have been incorporated,

Of particular interest to all, it was announced on January 23, 1973, that new requirements are being considered for life saving fire protection devices in homes, apartments and high rise buildings. Because all buildings may at some time be used to accommodate the elderly and the handicapped, these new requirements are intended to provide acceptable standards and precautions for all people. Thus, standards for any building should be at least as adequate as those required for the elderly or the handicapped.

D. DESIGN

The Minimum Property Standards provide general guidance in matters involving the design features of elderly housing. On going research is being directed to evaluation of the design of existing projects (see Research Section VII). Continued emphasis will be given to improved design and the development of the most desirable conditions in housing for the elderly and the handicapped.

E. HOUSING FOR THE HANDICAPPED

To date HUD has funded some seven multi-family projects specifically for handicapped persons. Some of these projects are for one type handicap such as the blind and others respond to a variety of physical handicaps.

1. *Vistula Manor, Toledo, Ohio*, opened 1967. This is available to persons with all types of physical handicaps. It is sponsored by the Toledo Metropolitan Housing Authority, for both elderly and handicapped, and 22 percent of the units are occupied by the handicapped (project preceded and evaluated by a HUD study grant under the Low Rent Housing Demonstration program.)

2. *Pilgrim Towers, Los Angeles, California*, opened in 1968. This is a Section 202 direct loan project sponsored by the Pilgrim Lutheran Church of the Deaf. Eighty-five percent of its 112 units are occupied by deaf persons. There is a special intercom system based on flashing light signals, and a closed circuit TV channel, by which management can communicate with the residents. In addition, the presence of so many deaf persons make communication with each other comfortable and natural.

3. *Walter B. Roberts Manor, Omaha, Nebraska*, opened in 1969. This is a Section 221(d)(3) BMIR rent supplement project sponsored by the Omaha Association for the Blind. Of the 41 units about half are occupied by totally blind persons and most of the rest by those visually handicapped. Braille tapes and cards are the main features of written communication in this building.

4. *Center Park, Seattle, Washington*, opened 1970. This is a low rent public housing project sponsored by the Seattle Housing Authority, with many architectural features modified from the experience of Vistula Manor in Toledo. The 150 units are largely occupied by the handicapped, with many different physical disabilities. A major facility for the service needs of the handicapped is expected to be constructed under the auspices of the Seattle Handicapped Club during 1973, and this will help complete the project as a functioning entity.

5. *Highland Heights, Fall River, Massachusetts, opened 1970.* This is a low rent public housing project sponsored jointly by the Fall River Housing Authority and the local Hussey Hospital, a rehabilitation hospital for the disabled and handicapped. The 209 units are largely occupied by the handicapped, although 80% of them are elderly, too. Many unusual design features are incorporated, but the most unusual aspect of its operations is the very intensive social and medical programming that links the project very strongly to the outside community, rendering excellent service on the way. In addition, HUD and HEW sponsored research projects are under way to examine resident satisfaction with the new facility.

6. *New Horizons Manor, Fargo, North Dakota,* opened 1972. This low rent housing project was sponsored by the Fargo Housing Authority, based on further modification of the design lessons learned from Seattle and Toledo. As of December 31, 1972, 70 of its 100 units were occupied exclusively by the handicapped. This building may be one of the best designed to date for disabled persons with physical handicaps. However, since it has just started up, its service and medical programming, too, is just getting under way.

7. *Independence Hall, Houston, Texas,* opened January 1973. This is a Section 236 project sponsored by Goodwill Industries of Houston. It contains 292 units, basically in two-story arrangements, which will be occupied over a six-month period during 1973. It is designed for the various physical handicaps, similar to Center Park, Highland Heights, and New Horizons.

In addition to activity related to the physically handicapped, the President, in his 1971 Report on Mental Retardation, requested HUD to study housing potentials for mental retardees. In April 1972, after reviewing the statutory provisions and the definition of the "physically handicapped" in the 1964 Housing Act, HUD's General Counsel issued an interpretation that persons with certain neurological and other mental handicaps emanating from a physical base should be considered eligible under HUD housing programs. This broadening of coverage could provide residential opportunities for many heretofore excluded, as well as another alternative to institutional care. The development of adequate services is of course a vital prerequisite.

As a result of this decision, on April 28, 1972, HUD approved two plans under state-Federal financing in the Section 236 program for four group homes and one two-story apartment building to provide housing for mentally retarded adults capable of an independent life style in their communities. Supportive services will be provided by local, private and government agencies. Since these are the first HUD projects for retardates, they warrant some detail.

One development in Detroit, Michigan, would provide two group homes of two stories each providing 16 one-bedroom apartments for monthly market rents of $204 per unit. This rent would be reduced to a basic rent of $130 per month by utilizing the one percent interest rate provided under the Section 236 program. Additionally, these are two two-bedroom apartments with market rents of $235 per month and basic rent of $149. The mortgage will be insured by the Michigan State Housing Authority.

The second project is in Farmington Township, Michigan, includes two group residential homes with 18 units and one two-story apartment building of 20 units. The State will also insure the mortgage on this development. Monthly market rental rates are $199 for the one-bedroom apartments and with the interest reduction, the basic monthly rent will be $122. The two-bedroom apartments market rate is $254 and the basic rent under Section 236 is $156 per month.

The unique feature of this effort is that the State, through local private corporations, accepts responsibility for the construction, funding, and operation of these projects. This is the first involvement of HUD in helping to provide housing for the mentally retarded adults other than those who can live completely independent lives in any of its several programs. It also is an example of state and local initiative, with responsibility for operations and support services at the local level. While FHA Minimum Property Standards must be adhered to in construction, the State accepts responsibility for design concepts responsive to group living.

In addition to the above projects, HUD has actively encouraged local housing authorities and the management of private multi-family low income housing to explore and provide through local public and private community resources, the development of needed services by cooperative efforts. HUD involvement in existing programs for the mentally retarded has been to authorize local housing authorities and private ownership to provide on-site space for such purposes.

According to a study on the Economics of Mental Retardation by the President's Committee on Mental Retardation, children of the poor are more likely to suffer the problems of mental retardation than children of the middle and upper classes.

Therefore, Federally-aided programs which provide community centers located in low income neighborhoods are a resource to local mental health agencies and their clientele. Some examples of the use of existing HUD-aided facilities in behalf of the mentally retarded include the following:

The *Newport, R.I.* Housing Authority provides space for a continuing program for the mentally retarded.

The *Baltimore, Md.* Housing Authority provides space to the Board of Education for programs for the mentally retarded.

The *Denver, Colo.* Housing Authority leases 15 units that are used as a dormitory for 40 mentally retarded students over 16 years of age who are receiving vocational and occupational training.

The *San Francisco, Calif.* Housing Authority provides space in one of its Chinatown projects for a day care center for the mentally retarded.

IV. Housing Management and Services

HUD has taken many actions to provide the elderly with an environment for full and independent living. The actual effectiveness of such efforts is, of course, dependent upon management.

A. MANAGEMENT OF HOUSING FOR THE ELDERLY

1. National Center for Housing Management (NCHM)

In April 1972, acknowledging concern over the growing number of subsidized multi-family structures and the limited availability of qualified managerial personnel, the President authorized the incorporation of a National Center for Housing Management. Operating initially under a HUD contract, the Center is intended to become self supporting. Its specific goal is to develop a professional housing management industry.

The Center, moved quickly and initiated its pilot course of instruction in November 1972.

The NCHM scope of work under its Contract with HUD provides: "The Contractor shall also develop a training course for managers of housing for the elderly, including conventional, congregate and intermediate care type projects." The initial pilot training program now underway does not include this component. However, a Training Grant for $126,296 has been made to NCHM through the AoA for the period from January 1 to June 30, 1973. The Grant will provide NCHM staffing of social gerontologists experienced in housing, and an advisory committee of multi-disciplinary professionals to assist in the development of curricula.

2. Housing Management Improvement Program (HMIP)

In September 1972, HUD announced the award of approximately $25 million in three year contracts to 13 of the Nation's local housing authorities to conduct demonstration programs testing techniques to improve the operation and management of public housing. Although all of these programs will offer significant benefits for the elderly occupant, five include demonstrations specifically directed to the elderly. This program is described in greater detail in Section VII—Research.

3. Security

Concern for the safety of elderly residents in low rent public housing has given momentum to several actions during 1972.

a. Security Handbook

Early in 1972, HUD conducted a seven city survey of security problems and programs in public housing and insured housing.

It has recently been decided to publish these materials in the form of a Handbook which will be ready for publication in early 1973.

The new Handbook will be aimed primarily at local housing authorities and the owners and managers of multi-family HUD-insured housing, although it will have a secondary utility for HUD field office staffs, managers and residents of all housing. The Handbook will concentrate on "software" considerations, with cross references to other publications in regard to design and "hardware." It will focus on practical planning and provide an introduction to the subject for owners and managers who need a central point of reference.

b. Survey of LHA Security Expenditures

The purpose of these reports is to provide HUD with information on the extent of budgeted protective services expenditures. As of recent date, 307 LHAs had reported, representing 101,877 dwelling units. These reports show that the 307 LHAs spent $2,735,437 for security, using resources available from rental income, local governments, HUD and other Federal sources.

c. Security Action Group

This is an inter-agency group convened through the cooperative efforts of HUD-LEAA-The Administration on Aging (HEW), Senate Special Committee on Aging, U.S. Conference of Mayors, National League of Cities, National Association of Housing and Redevelopment Officials, National Tenant Organization, International Association of Chiefs of Police and National Governors Conference. The Group has met three times—in September, October and November of 1972.

The purpose of the group is to improve coordination of programs for assistance to LHAs in the field of security. As the membership indicates, stress, has been placed on the roles of the state and local officials and local tenant organizations, as well as inter-agency coordination at the Federal level. Further meetings will be planned in the near future.

d. "Demonstration" LHA Security Programs

Significant security components are involved in two demonstration type public housing improvement programs, the new 13 LHA Management Improvement Program (mentioned above) and the Innovative Modernization Program. In each demonstration the local housing authority, in cooperation with the local government, will demonstrate improved methods in security for residents of public housing.

The three Innovative Modernization Housing Authorities are San Francisco, Cuyahoga Metropolitan Housing Authority (Cleveland), and Allegheny County, Penna. Each of the Housing Authorities was funded with approximately one million dollars of combined Housing Modernization and Research and Technology monies for this effort.

The security improvements being tested include new design concepts, improved access control, surveillance systems, redesign of pedestrian traffic and play areas, improved locks and lighting, tenant volunteer patrols, specialized security staff, efforts to reduce vandalism and delinquency. Most authorities are also devoting considerable attention to the education of tenants as to their important role in the fostering of security. This also includes attempts to develop a greater sense of community within housing projects.

The Management Improvement Program is being monitored by both HUD Central Office and field staff and the entire effort is being evaluated by the Urban Institute.

B. SERVICES

Comprehensive services for the elderly depend upon the dedication and the success of the local community in marshalling and delivering available resources. A number of HUD actions noted below, which were taken during 1972, are directed to that objective.

1. Community Services

HUD Circular HM G 7471.1, dated June 1972, presented a plan for possible actions and encouraged close association between LHAs and the community. Senior Centers, another essential facility for most cities, will be discussed separately.

2. HUD Listening Post, Seattle, Washington

The first major project initiated under a cooperative agreement signed by the Department of Housing and Urban Development, ACTION, Administration on Aging, and the National Center for Voluntary Action on June 29, 1972, will be the establishment of a "Listening Post" to provide information and referral on housing and housing related problems to all the people of the State of Washington and eventually on a phased basis, to a three state area. The key element in this research and technology program will be the training and utilization of approximately 150 to 200 elderly volunteers recruited under the Retired Services Volunteer Program, Service Corps of Retired Executives, and the Administration on Aging programs. They will provide the nucleus of a vast outreach volunteer

effort to provide service on a one-to-one basis to people in need of help and will serve to provide a meaningful link to those agencies of Federal, State and local governments charged with specific responsibilities in the area of housing and the delivery of social services. The potential service to older people in need of help is considered significant.

The linkage will be provided through the use of trained volunteer listeners, wide area telephone lines, and access to computer files listing all available volunteers, private and governmental resources available to meet needs expressed and verified by the volunteer trained listeners and Information and Telephone specialists recruited from the State's elderly population.

3. Administrative Improvements

During 1972, two significant management guides relating to the elderly and handicapped were released by HUD. The first was HM G 7460.1, the Guide to the Management of Congregate Housing. This booklet discussed the differences between housing for the elderly and congregate housing and details of the food service component that mark their differences.

The second was HM G 7460.3, the Guide to the Management of Housing for the Elderly. This is a detailed discussion of the nature of elderly housing, the characteristics of its sponsorship and management, resident selection, occupancy and orientation. It also includes a full discussion of the prime needs of the elderly, including health, medical care, nutrition, income maintenance, financial problems, mobility, transportation, community services and security.

With the increase of Social Security benefits in September 1972, Housing Management also issued a guideline to housing authorities, suggesting that adjustments in rent only be made at the time provided for by HUD-approved LHA policy, or as provided in the lease. The guideline also reminded the LHAs of the provisions of the Housing Act that permit higher-income families to remain in occupancy under certain conditions.

4. Senior Centers

The Department of Housing and Urban Development assists in the development of community centers. Such facilities may be constructed as part of housing developments insured by HUD. Also, the Department has provided a number of facilities in the past under the Neighborhood Facilities Program. However, this has been a limited and relatively inflexible categorical program and a more flexible source of funds will be available in the future through special revenue sharing under the President's proposed Better Communities Act.

5. Joint HUD-HEW Agreement

As noted above, comprehensive services for the elderly residents are dependent upon the initiatives of the local community. To enhance such services, local housing authorities may use their funds as "matching funds" for social and rehabilitative services obtainable through the state plan for such services. The state plan is approved and financially supported by the Department of Health, Education and Welfare. The Department of Health, Education and Welfare is now in the process of developing new regulations to implement the $2.5 billion ceiling on social services funds enacted with the General Revenue Sharing program.

An example of joint efforts can be found in Inkster, Michigan, where the housing authority's Twin Towers project for the elderly provides its 250 residents and 1,000 elderly from the community with a range of services. Programming of the services is in the hands of the local Commission on Aging. The services include information and referral; outreach; transportation; homemaker and health and related services. Paid volunteers, some of whom live in Twin Towers, perform many of the services, with a full-time coordinator in charge of the volunteer operations. Total funding for the program amounts to $124,000—three-fourths from HEW and one-fourth from the Housing Authority, whose contribution was shared in the amount of $6,000 by New Detroit, a local private agency.

In addition, a current survey of local housing authorities over the country shows that by and large, all housing projects for the elderly have community space in which recreation programs and other activities take place. Volunteer groups, as well as public agencies, such as municipal parks and recreation agencies, provide services, though a number are tenant sponsored and operated. Food service is less usual and is largely limited to "meals on wheels." Other samples of inno-

vative activities in local housing authority operations for the elderly are worth noting:

Duluth, Minn.: The community center built by the housing authority will serve public housing residents in three high-rise buildings for the elderly as well as other residents of the neighborhood. A feature of the center is the sizable space for a clinic—1500 square feet—staffed by the local university medical school and the public health department.

Roanoke, Va.: Sixteen thousand square feet of community space in the Melrose Towers project is used for a health clinic, physiotherapy, counseling and special purpose rooms, such as craft. The project presently has a grant of $50,000 from the State to provide services.

Hampton, Va.: Elderly residents are sponsoring Boy Scout and Girl Scout troops.

Montgomery County, Md.: Health Department hold group therapy sessions weekly for residents of the Fenwick Project, as well as an experimental Alcoholics Anonymous program. For the three projects for the elderly under the housing authority, a mobile health unit provides clinic services of three doctors and three nurses.

Glassboro, N.J.: A foot-care program is provided through Housing Authority efforts. The Portland, Ore. Housing Authority also provides space for a podiatry clinic in their five projects for the elderly, as well as an on-site dental clinic 1½ days a week.

Syracuse, N.Y.: Toomey Abbott Towers for the elderly was built with a community dining hall, library and meeting center that also serves Syracuse University students. An evaluation of the inter-generational living experiment is now being made with a view to helping other communities that wish to try this approach to community living.

Maricopa County (Phoenix), Ariz.: Mobile homes under the HUD Sec. 23 leasing program provide residences for 100 elderly individuals and families. The AoA, through "Meals on Wheels", provides one meal a day, and the Arizona State School of Nursing gives health services.

Clackamas County, Ore.: 100 units of scattered-site housing in a rural setting are served by a post office substation and a small commercial grocery provided specially for the purpose. The Community College waives all fees for residents of elderly housing enrolling in adult education. The public library provides rotation of books on a bi-monthly basis, plus audiovisual materials, and Talking Books for the visually handicapped.

Akron, Ohio: The Dairy and Nutrition Council, in collaboration with the local health department, conducts an "Eat What You Want and Stay Young" program in its projects for the elderly, which are located in the Model Cities area.

San Antonio, Tex.: Special activities in the eight housing projects for the elderly include regularly scheduled health consultation classes with medical students and nurses from the University of Texas Medical School; full-time resident transportation to shopping and health facilities; and an ongoing cultural program with local drama and theater groups.

Dade County, Fla.: A "New Move-In Visitation" program is popular with tenants. A social worker, provided by the Dade County Housing Authority, visits new residents as they are settling in and helps them adjust to their new environment. A follow-up visit is made to evaluate their adjustment and to help solve any problems.

In public housing developments that offer physical facilities for Senior Centers, usually operated by the city through a local Committee on Aging, current services often include health clinics as well as recreation programs, and may be the center for some meal serving. Elderly people living outside the public housing complex are generally given the opportunity to enjoy the Senior Center services.

V. Equal Opportunity

During 1972, HUD expanded efforts to provide equal housing opportunities for minorities. The numerous activities benefiting minority segments of the population are of direct advantage to the elderly members as well. A new project selection method has enhanced consideration of minority needs. Newly constructed projects are now required to market affirmatively to the minority segment of the population. Also, HUD support of minority entrepreneurship has yielded benefits to minority consumers.

HUD is aware of a need to increase minority occupancy opportunity for the elderly, especially in projects developed for the moderate income levels. Emphasis will be given to this need during 1973.

VI. Community Planning and Management

HUD administers a series of programs and activities designed to improve the quality of life for persons of all ages. Two of these activities: the "701" Planning and Management Assistance Program, and the New Communities Development Program have particular significance for the older population.

A. "701" PLANNING AND MANAGEMENT ASSISTANCE

Planning for the elderly is an eligible activity under the "701" Planning and Management Assistance Program. Agencies (governor's offices, local officials and others) funded through the "701" program have the latitude to include efforts to assist the aging. Not only are these fund recipients the key decision makers for any such efforts, but many of the activities they are now carrying on with grant assistance from this program are directly relevant to, and provide a solid foundation for, specific planning for the elderly. Some examples are: demographic studies of the age composition of state, regions, and localities; income studies; studies of housing needs by age; land use studies, forecasts and plans relating housing for the elderly to the transportation, community facilities and recreational needs of various age groups.

Utilizing a Section 701(b) grant, in 1972 the American Institute of Planners published a technical guide for regional housing planning. The guide gives special emphasis to the elderly and serves to illustrate one area of support from federal planning and management assistance programs.

B. NEW COMMUNITY DEVELOPMENT

By the end of 1972, HUD had approved 14 new communities, including two new towns in town, which have a combined total projected low- and moderate-income housing level of 67,502 units over a period of 20 years. This is 27.9% of the total number of 245,441 units for these new communities. It is expected that a significant number of the units will be for the elderly, although the developers generally are not committed to a specific amount.

The New York Urban Development Corporation, the developer of Welfare Island and Lysander, has promised to use its best efforts in each project to provide for elderly low income housing: 10% of the total housing units, or in each case, 500 units. In addition, Welfare Island, has a major hospital and other amenities which should make it particularly well suited for the elderly.

One new community, San Antonio Ranch, with 10,314 units of low- and moderate-income housing, of which 2,948 is for low income, should make a major contribution to housing for the Spanish speaking. It is expected that a representative amount of this housing will be for the elderly, depending on demand and other factors.

Units projected for completion and occupancy in the new communities moved ahead during 1972 generally as called for in the development plan.

C. PROPERTY TAXATION

The unfortunate impact of property tax on the elderly homeowner has been widely noted. On March 1, 1973, the President stated his intent to submit new legislative proposals to alleviate this burden. In keeping with the Administration's concern, several supportive actions have been taken to enhance state and local tax planning.

Section 701(b) of the Housing Act of 1954 authorizes the Department of Housing and Urban Development to make grants to assist in the conduct of studies and research into needed revisions of state statutes which govern or control local governments and local governmental operations

The Department recently allocated funds for a study to be made by the University of Texas with respect to property tax reform. The study will analyze Texas State statutes governing the State and local government powers and procedures for administering property taxes. In addition, a model comprehensive system of property tax administration will be designed as part of the project.

The Department is interested in a major research project being developed by Vermont to study property tax reform. The project will analyze and consider a replacement of the ad valorem real property tax with substitute taxes based on an "ad rem" use tax, a property transfer tax and a town income tax.

Title V of the Housing and Urban Development Act of 1970, which consolidated the research and technology authority for the Department, authorizes the Secretary to undertake research and demonstration projects in relation to the mission and programs of the Department. Although the contracts listed below are not with states or municipalities, they involve the study of the special effects of property taxes and may be relevant in future deliberations by communities:

The Relation Between Property Taxes and Urban Blight; Arthur D. Little, Inc. Contract Amount—$122,000 (H–1299).

The Effects of Property Taxes in Urban Development; Price Waterhouse, Inc. Contract Amount—$77,478 (H–1300).

Tax Consideration on Multi-Family Housing Investment, Touche Ross, Inc. Contract Amount—$138,650 (H–1227).

VII. Research and Technology

To support the new emphasis for the elderly and to provide a focal point for all research relating to the elderly and handicapped, a staff member trained in gerontology was designated as the specialist to coordinate with other specialists within the Department, coordinate inter-agency activities in research, consider unsolicited proposals and develop research objectives, strategy and priorities.

Although the research conducted in the past did not compose a cohesive whole, the results were useful and will serve as the basis for future research under the new strategy. The following is a presentation of research underway, or completed in 1972.

A. UNDERWAY

1. Operation BREAKTHROUGH

Phase I included 486 units of housing specifically designed for and financed under the elderly housing provisions of the low rent public housing program. These developments are located in Memphis, Kalamazoo and Sacramento. Special features include experimental safety features such as smoke detectors and a personal silent alarm system specifically for the elderly. Design of these projects also took into consideration the comfort and health of the older resident as well as his personal safety and, therefore, will be useful to all housing built under the industrialized housing concept.

Bathtubs were eliminated in some units and substituted with shower stalls to test the theory of elderly being reluctant or unable to negotiate a tub. Balconies were constructed with solid face and open grill work to test if elderly felt a difference or were reluctant to use balconies with a very open design. In one building some units were constructed with bathrooms in master bedrooms while others had bathrooms off hallways, again to test user needs and desires. Feedback testing will be accomplished to determine the most acceptable practices. An additional 1,946 units for the elder y are to be sold or rented.

Operation BREAKTHROUGH projects also developed innovative site planning and unit designs which result in more accessible dwellings and community facilities. These are important components in housing for the elderly and will contribute to extending the span of independent living, reduce maintenance costs and provide opportunity for continued participation in the community. Evaluation of the completed developments using the new technology is continuing.

2. Housing Allowance Experimental Program

The Housing Allowance Experimental Program was begun in 1972 to evaluate housing allowances as an alternative to other concepts for housing assistance. The findings of this experimental effort remain uncertain. Elderly residents are to be included in both the recipient and control groups. This program provides a rent allowance direct to the eligible individual or family to make the difference between his rent paying ability (25% of income) and the rent of available housing units. The residents find and select their own dwellings within certain cost limits. Many factors may bear upon the housing choice by the elderly such as closeness to children or grandchildren, desirability of a known or safe neighborhood or a location near long time friends, or an area offering facilities of interest within walking distance. Dwelling size and adequacy as well as rent paying ability also

will be considered by those desiring to live in existing housing. Use of appropriate available housing permits another choice of life style most acceptable to the taste and desires of the elderly person needing or seeking an improved living environment.

3. Public Housing Management Improvement Program

The Public Housing Management Improvement Program contains service components specifically for the elderly in five of the 13 three year contracts approved in 1972. This program is a major effort to demonstrate and evaluate improved methods of operation and management of public housing and thereby to improve the quality of life for residents. HUD is providing research and technology funds to local housing authorities, who, together with local governments, are responsible for the design and implementation of the approaches to be taken. While the anticipated improvements in all 13 of the cities will benefit the elderly residents of all the projects, the five cities specifically addressing the needs of the elderly residents as well as those living in the adjacent neighborhood are New Haven and Hartford, Connecticut; San Juan, Puerto Rico; Greensboro, North Carolina; and Atlanta, Georgia. The effectiveness of these programs without doubt will have long range benefits to all operators of housing for the elderly and will be particularly useful to new sponsors seeking to develop programs of maximum benefit and usefulness to the elderly.

Examples of management improvement experiments include the New Haven survey to determine the needs of an outreach service using social case work skills of six Yale University Divinity students. In addition to determining comprehensive needs of the elderly population, preparation is underway to meet these needs through Meals on Wheels, free transportation and improved recreational and educational activities. The Atlanta program will test means of preventing premature institutionalization of its older residents and will develop programs to alleviate loneliness and promote self-sufficiency. Hartford, recognizing the changing needs as tenants age, will explore the use of congregate housing for elderly residents and non-residents unable fully to care for themselves. In San Juan, Puerto Rico, the emphasis will be on providing needed services to residents and non-residents using elderly tenants, some 200 of whom will be trained as housekeeping aids and/or equipped to provide other services needed by the more frail older people.

4. Law Enforcement Assistance Administration Contract

The Law Enforcement Assistance Administration Contract negotiated in 1972 is designed to investigate the problems of residential security. The elderly are particularly vulnerable to the effects of crime and vandalism. Application of techniques resulting from this study are more fully described in Section IV.)

B. RESEARCH COMPLETED IN 1972

1. Brown Engineering Company Home Accident Study

The Brown Engineering Company study delineates the cause of home accidents by age groups and reveals the relationship of certain home features that have proved dangerous to the elderly resident. Poor design or lighting on stairways, absence of railings, unmarked glass doors, certain bathroom and kitchen design and equipment may result in unnecessary accidents. The study included evalution of HUD standards related to accident reduction. The findings of this study will be reflected in the Minimum Property Standards or the Manual of Acceptable Practices now under revision.

2. Fall River, Massachusetts Housing for the Handicapped Study

Evaluation of housing for the handicapped in Fall River, Massachusetts from the medical, social, economic and tenant satisfaction points of view was completed in 1972. The full report will be published by HUD in 1973. The value of special design, of specific services such as health and therapy facilities in the project and in the adjacent hospital were included. The majority of the residents of this project are elderly as well as handicapped. Some of the residents who came from nursing homes provided opportunities to test whether a residential development adequately could serve their needs given certain services. The findings were positive and provide data that may be used to forestall premature reliance on costly medical institutions rather than continuing in a more normal living environment. Consideration is being given to an extension of this research to further define the types of handicapped individuals who would most benefit from like facilities.

3. Fisk University Mobility Study

A Fisk University study to provide data related to relocation programs for the elderly, the effect of mobility on the availability or lack of public transportation and the health, income and service needs of the elderly was completed in 1972. Draft of the final report to be published by the University has been approved. This study was conducted in Nashville, Tennessee, and respondents were both black and white elderly. The results have particular significance for minority elderly and policies and programs related to them.

4. Housing Annuities for the Elderly—University of California

A Housing Annuities for the Elderly Study conducted some time ago by Professor Yung Ping Chen of the University of California is now in the process of being published. This study was done among homeowners aged 55 to 75 in Los Angeles County to measure their attitude toward the idea of converting the homeowner's equity into a flow of monthly income for life. Reactions to the concepts were mixed, but the researcher found that those most sympathetic to the concept were those who had not paid off their mortgages, those who felt their retirement income was inadequate, those who had no children or grandchildren and those who are among the younger members of the study group. The study found that 9% of the respondents were interested in the plan, 4.2% were indifferent and 86.8% were disinterested. However, the researcher did not find this discouraging. He felt that more people would be interested if it were better explained as an opportunity to improve living standards through use of equity in the home.

5. Forecasting International—Bibliography

Forecasting International, working under a HUD contract, completed a state of the art study and bibliography on housing for the elderly with special emphasis on the problems of management in such housing. This report is undergoing analysis for use in HUD improvement efforts related to housing for the elderly.

C. ADMINISTRATION ON AGING HOUSING RESEARCH

The Administration on Aging because of its interest in all aspects of the aging problem has funded four major environmental studies which will be useful to HUD and its program evaluation and improvement effort. A brief outline of these studies follows.

1. Gerontological Research Institute, Philadelphia Geriatric Center (Home for the Jewish Aged)

Grant of $261,959 for a project to study the effect on older people of a new form of housing called "Intermediate Housing." The Home has purchased nine small row houses in the neighborhood of the Geriatric Center and will reconstruct and renovate them to accommodate from 27 to 36 older people in low cost, private efficiency apartments. The term "Intermediate Housing" was chosen to indicate something between total institutional care on the one hand and completely independent living on the other.

The new housing will be provided at a cost within the means of public assistance recipients and those dependent on Social Security. The tenants will be permitted to bring their own furniture if they wish but this will be supplemented by the Center. Building maintenance janitorial services, utilities, and heavy cleaning will be provided by the Center, with the costs absorbed as part of the rental. The purchase of the houses is being made possible through FHA mortgages. The continuing service pattern will vary in accordance with the needs of each individual. Examples of services are: homemaker, telephone checks, and transportation. The services of existing community agencies will not be duplicated, but the Center staff will mobilize, coordinate, and supplement existing services when necessary.

2. Gerontological Society, Washington, D.C.

A $292,321 grant to develop basic information and stimulate policy action decisions on housing for aged including construction design. A series of seminars will be held involving authorities in the fields of aging and environment including architects, developers, psychologists, sociologists, social workers, social planners, and administrators.

The seminars will focus on design and patterns of living. There will be sessions on private and public age-segregated housing; nursing homes and homes for the aged; institutional environments, and alternative living arrangements, such as

center city hotels, trailers, regular housing. In addition, some attention will be paid to patterns used in other countries—Canada, the British Day Hospital, and the Israeli kibbutz.

3. Philadelphia Geriatrics Center

This is a study of existing housing programs for the elderly in terms of the architectural design, site location, management and administrative policies in relation to perceived needs and wants of management and of tenants of elderly housing. Cost factors associated with various housing alternatives and with various service options under any given housing type are also being examined. Preliminary findings were used in testimony prepared for the hearings before the Senate Special Committee on Aging, Subcommittee on Housing, August 2–4, 1971. When the project is completed, the findings should be significant for HUD and HEW officials. The projects being studied are geographically distributed public housing and Section 202 developments for low- and moderate-income elderly.

4. Institute for Community Studies, Kansas City, Mo.

A research and demonstration project to devise and demonstrate ways to adapt and utilize existing housing provide an alternative living arrangement for elderly persons in need of more appropriate housing. The project will focus on the establishment of "affiliated housing units," a democratic cooperative living arrangement, whereby members would agree to share expenses, duties, and responsibilities. The project will also include a survey of older persons in the process of making decisions about changing housing and living arrangements and a survey of types of joint and/or congregate living currently existing.

VIII. Interstate Land Sales Regulation

Prospective middle and moderate income homeowners, searching for vacation or retirement homes are also a point of concern to HUD.

The Interstate Land Sales Full Disclosure Act (Title XIV of the Housing and Urban Development Act of 1968) requires the registration of subdivisions offered for sale in interstate commerce.

The Act generally applies, by law and administrative regulation, to all subdivisions of undeveloped land containing 50 or more lots. Safeguards for consumers are provided through statutory and regulatory penalties imposed upon developers who fail to file and keep a registration statement current with the Office of Interstate Land Sales Registration (OILSR) or who fail to furnish each purchaser with a copy of an approved Property Report at the specified time.

Older Americans are often the target of unscrupulous land development schemes and are especially susceptible to sales promotions accenting retirement and investment opportunities. During 1972, OILSR conducted 34 hearings in 17 cities across the nation, in order to gain insight into the kinds and volume of consumer complaints. Many of those who testified were eldery people who purchased land with a dream of future security only to have it end in a nightmare.

OILSR has assisted many people who find themselves in this predicament by interceding on their behalf with the developer. Since the beginning of the program, OILSR has assisted in securing over $1,000,000 in refunds for purchasers. During 1972 alone, OILSR took over 200 administrative actions against land developers many of which led to the suspension of the developer's right to sell land. In addition, three criminal convictions and two indictments were obtained against land developers through a stepped up enforcement campaign.

IX. Disaster Assistance

The Wilkes-Barre, Pennsylvania Disaster Office was primarily responsible for assistance to elderly flood victims in Luzerne and Columbia Counties. A large percentage of the inhabitants of these counties are elderly due to the migration of the young after the decline of mining.

HUD disaster assistance in Pennsylvania consisted of Interim Housing, Group Mobile Home Parks, and Scattered Sites. Interim Housing, consisting of hotel and motel accommodations was offered to flood victims until temporary housing became available. Leases for the elderly were negotiated with landlords for 35 families. HUD also paid bills for other elderly victims of the flood in a number of hotels.

Of all families housed in group sites (Corps of Engineers developed parks) for temporary housing assistance, approximately 40% or 1,000 were elderly families.

Scattered Sites, consisting of private site mobile homes, mini-repair, government-owned housing and private rentals, provided for 9,422 families, of whom approximately 35% were elderly.

HUD also worked with the President's Committee for the Elderly established to assist the aged in the flood area in solving their housing problems and to reduce the impact of the disaster on the older flood victims.

ITEM 9. DEPARTMENT OF THE INTERIOR

FEBRUARY 23, 1973.

DEAR MR. CHAIRMAN: Your letter of December 15, 1972, to Secretary Morton requested a statement summarizing this Department's major activities for older Americans.

Briefly, this Department's activities on behalf of older Americans are aimed at demonstrating a continuing concern for our retired employees and providing the encouragement of minimum cost in the use and enjoyment of public lands by older citizens. Many of our bureaus have instituted plans to keep their retired employees informed of bureau activities through periodic news sheets. The Bureau of Land Management, for example, mails copies of the "BLM Newsletter" and bimonthly edition of "Personnel Highlights" to its retirees. In addition, bureau retirees receive a monthly newsletter "The Retirement Advisor" which is subscribed for them by the bureaus from Retirement Advisors, Inc. This publication contains information useful to retired persons regarding their rights, opportunities, etc.

With regard to facilitating enjoyment of public lands by older citizens, this Department issues the Golden Age Passport, which is free of charge to persons over 62 years of age and allows a 50 per cent discount on all fees charged on recreation areas of public lands.

Sincerely yours,

CHARLES G. EMLEY,
Deputy Assistant Secretary of the Interior.

ITEM 10. DEPARTMENT OF LABOR

JANUARY 16, 1973.

DEAR MR. CHAIRMAN. I am enclosing the updated material which you requested for your Committee's report entitled, "Developments in Aging—1972."

Of particular note last year was the doubling, both in funding and job slots, of the special job projects for older persons. This expansion resulted in a total of more than 10,000 work opportunities for low-income persons 55 years or over.

Sincerely,

J. D. HODGSON,
Secretary of Labor.

[Enclosure]

A REPORT ON PARTICIPATION BY OLDER WORKERS IN MANPOWER TRAINING AND THE OPERATION MAINSTREAM PROGRAM

The Manpower Administration has continued in its efforts to train older workers for available jobs in industry and government. In addition, it has attempted to increase the use of older trained, unemployed, or retired persons to fill the positions of supervisors, counselors, and administrators in the manpower programs. Experience has shown that older workers, especially indigenous ones establish particularly good rapport with the enrollee. Older workers also 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 to improve community resources and in so doing has provided an effective 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. Operation Mainstream, Title I–B funds for Fiscal Year 1972 consisted of the appropriation level of $38.8 million plus $24.3 million reprogrammed from other manpower programs, including $13 million to expand job programs for low-income older workers as directed by the President. 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 regular 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."

In Fiscal Year 1972, two of the former National Office Older Worker contracts were transferred to the regional office in Philadelphia because their scope of coverage was local. They are Virginia State College and the Total Action Against Poverty in Roanoke Valley. They were replaced, however, with two new national contracts. They are the Federation of Experienced Americans and the United States Forest Service. These contracts were awarded during the $13 million expansion of the Older Worker program. Additionally, $2 million was allocated to the regional offices for Regional Older Worker Projects. Following are the National Office Older Worker projects with their new annual funding levels.

Sponsors	Slots	Annual funding level	Dates
National Council of Senior Citizens (NCSC)	1,848	5,246,912	Nov. 19, 1972–Aug. 31, 1973.
National Council on The Aging (NCOA)	844	2,272,608	July 30, 1971–Jan. 31, 1973.
National Retired Teachers Association (NRTA)	1,710	4,421,245	Sept. 22, 1971–Apr. 30, 1973.
National Farmers Union	3,704	8,960,160	July 30, 1971–Jan. 31, 1973.
United States Forest Service	775	2,000,000	June 26, 1972–June 25, 1973.
Federation of Experienced Americans	350	1,000,000	June 30, 1972–June 29, 1973.

1. National Farmers Union

Green Thumb.—During Fiscal Year 1972 the project was expanded by 775 enrollee slots at a federal cost of $2,000,000. The program now operates in 24 States and the commonwealth of Puerto Rico.

Green Light.—It is anticipated that during Fiscal Year 1973 this component will be consolidated with Green Thumb.

2. National Council on the Aging

During Fiscal Year 1972 this program was expanded by 272 enrollee slots at a federal cost of $700,000. Seven new sites were picked up making a total of 18 sites.

3. National Retired Teachers Association

During Fiscal Year 1972 this program was expanded by 1,355 enrollee slots at a Federal cost of $3,500,000 which expanded its operations to 31 locations.

4. National Council of Senior Citizens

This program was expanded during Fiscal Year 1972 by 700 enrollee slots at a federal cost of $1.8 million, which increased its operation to 34 sites.

5. The U.S. Forest Service

This new program was established during the expansion of the Older Worker Program. There are 775 enrollees participating basically in conservation and beautification type activities in 21 States. The cost to the Government is $2 million.

6. Federation of Experienced Americans

This is a new program basically involved with human service activities in 2 States, which are Florida and California. The program contains 350 enrollee slots at a federal cost of $1 million.

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 continued to exceed 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 citizens could overcome some of the aging problems such as fear, loneliness, and melancholy.

In Fiscal Year 1972, the Department of Labor reprogrammed $20.8 million to administer Operation Mainstream, Title I–E projects for another year. The Title I–E program was designed to be used as an economic tool to create 5,400 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, Title I–B projects.

The procedural difference is as follows: To maintain maximum flexibility in the use of funds so that new projects can be mounted in areas of greatest need, as conditions change, Title I–E projects are limited to 6-months duration. Renewals beyond 6 months must be based on evidence of a continued high unemployment rate for that area as compared to the previous year. (Participants originally were limited to a 13-week enrollment period with an option for one renewal. However, since it is frequently unrealistic to expect permanent placement for chronically unemployed adults living in small areas with significantly high unemployment, this 26-week limitation was removed and enrollees may remain until the project terminates or they are placed in permanent employment.)

ITEM 11. DEPARTMENT OF TRANSPORTATION

FEBRUARY 22, 1973.

DEAR MR. CHAIRMAN: In response to your letter of December 15, 1972, I am pleased to send you the enclosed statement describing the major programs and activities of this Department in assisting older Americans.

If we can assist you further, please let us know.

Sincrely,

CLAUDE S. BRINEGAR,
Secretary of Transportation.

[Enclosure]

DEPARTMENT OF TRANSPORTATION PROGRAM OF ASSISTANCE TO THE ELDERLY—1972

INTRODUCTION

In conjunction with the Department's overall efforts to improve transportation for all citizens, enhancing mobility for the nation's 21 million elderly citizens continues to be an important program objective. Since the elderly and handicapped experience many similar problems in using transportation, the Department's program efforts in this area have generally been geared to respond to the needs of both groups with a single effort. Thus, many of the projects discussed below are designed to serve the needs of both groups.

This report is divided into four sections. Section One presents the status of programs and projects discussed in *Developments in Aging—1971*. Section Two describes administrative actions taken by the Department to improve services to the elderly since that report was submitted in April 1972. Section Three describes programs which benefit the elderly which were initiated in 1972, and Section Four describes plans for followup during 1973.

SECTION ONE: STATUS REPORT ON PROGRAMS AND PROJECTS DESCRIBED IN "DEVELOPMENTS IN AGING—1971"

This section of the report discusses progress on those projects which were identified in last year's report.

1. *Accessibility of Metropolitan Washington Area Transportation to the Handicapped and Elderly.*—Last year we reported that a contract had been awarded

for the above study. Information gathered thus far indicates that the Washington Metropolitan Area Transit Authority has taken steps to make Metro, the Washington Subway System, accessible to the handicapped and elderly. However, we anticipate that the final report of the study will contain additional recommendations, which if implemented, will substantially increase Metro's accessibility to the handicapped and elderly. The study final report will be available in the Spring of 1973.

2. *Haddonfield, New Jersey Dial-A-Ride Demonstration.*—This demonstration described in the 1971 report began operation in March 1972. Ridership has risen to 4500 weekly and the system is providing a much needed service to a local medical complex which has a significant elderly clientele. 17% of ridership is over 65.

3. *Lower Naugatuck Valley, Connecticut; Helena, Montana; St. Petersburg, Florida; Klamath Falls, Oregon; Cranston, Rhode Island.*—These special service demonstrations were described in the 1971 Developments on Aging report. They are all designed to demonstrate innovative services and equipment to serve the special transportation needs of the elderly. Upon completion of the demonstration phase they will be used as models for communities across the nation to initiate like transit services for the aged.

4. *National Urban League.*—This study, described in the 1971 report, has led to an analysis of the transit needs of the elderly and handicapped in four diverse cities. It is planned that the data accumulated can be extrapolated to provide national data in like situations.

5. *TRANSBUS Program.*—Three contractors have been awarded contracts to develop a new standard 40-foot 50-passenger bus. Designs for those buses, 3 of which are to be accessible to wheelchair passengers, are nearly complete and it is anticipated that prototypes will be available in the fall of 1973. Public agencies will then be able to choose the best bus to serve its particular needs.

6. *Highway Traffic Safety.*—The pedestrian safety study has advanced to the stage where eight countermeasures have been installed at selected sites in several cities throughout the country. Pedestrian behavior is being monitored at these sites and countermeasures which show the most promise will be tested further in city-wide demonstrations to determine their effectiveness in reducing pedestrian injuries and fatalities.

SECTION TWO: ADMINISTRATIVE ACTIONS

The Department has taken the following actions since its last report to make its programs more responsive to the special transportation needs of the elderly.

1. In June of this year the Secretary signed a DOT Order creating a Departmental Coordinating Committee on Transportation for the Handicapped and Elderly. The Committee which is comprised of deputy assistant secretaries, and deputy administrators of the modal administrations, promotes the coordination of programs within the Department which deal with the transportation problems of these important segments of the population and suggests policy pertaining to the handicapped and the elderly. The Committee has met several times to discuss ways in which the Department might better respond to the special transportation needs of the handicapped and elderly. Since a large part of the Department's program activities in this area have been in the areas of research and demonstrations, the Committee has concentrated its efforts on developing procedures for coordinating Departmental efforts in these areas.

2. In March 1972, the Urban Transportation Advisory Council appointed a Committee to advise the Secretary, through the Council, on matters pertaining to transportation of the transit deprived, which includes the elderly. It is anticipated that this Committee will develop recommendations which the Secretary can use in establishing policy relating to improving public transportation for the elderly and handicapped. At the Committee's request a study is now being conducted by the Department's Transportation Systems Center which will examine urban public transportation to determine to what extent it is currently used by the handicapped and elderly. The study includes an analysis of census and other statistics on the elderly and handicapped by population, disability and transportation needs. It also includes a review of all literature and research produced on this subject. The final report will delineate the new and potential market for urban mass transportation by the elderly and handicapped.

3. In his message to the Congress on Older Americans in March 1972, the President stated that the Department of Transportation would give priority to technical study and capital grant applications which provide direct transit as-

sistance to the elderly. In response to this message, the Urban Mass Transportation Administrator issued a directive in April of last year implementing this mandate. In July of last year, the Secretary advised all governors and mayors of cities with populations of 50 thousand and over of this policy.

4. In the Administration's proposed legislation—Federal-Aid Highway and Mass Transportation Act of 1972—amendments were proposed to Section 16 of the Urban Mass Transportation Act of 1964 to permit the Secretary to establish standards for design and construction of mass transportation equipment and facilities so as to make them accessible to the physically handicapped and elderly. The proposed amendment would have given the Secretary the authority to withhold the approval of projects that failed to meet established standards.

SECTION THREE: PROGRAM ACTIVITIES INITIATED ON BEHALF OF THE ELDERLY DURING 1972

The following is a summary of Departmental recent program activities which benefit the elderly. These are described under the heading of the Departmental element that is responsible for their support.

I. Office of the Secretary

A. Transportation needs of the handicapped and elderly were made known directly to the Department through 37 consumer public hearings or "listening sessions" held in 12 states by the Department's Office of Consumer Affairs.

B. The Department has encouraged a program involving off-peak lower pricing in air transportation for all segments of the traveling public. For example, in testimony before the Subcommittee on Aviation of the Senate Committee on Commerce, the Department indicated that it favored the use of promotional fares "to fill excess seats in off-peak periods." On the other hand, the Department opposed past plans, such as student/youth fares which might be unjustly discriminatory to other travelers. We believe that lower fares during off peak periods are particularly advantageous for senior citizens who are more easily able to adjust their travel time.

II. Urban Mass Transportation Administration (UMTA)

A. Two new State-of-the-Art cars (SOAC) have been built and are being tested at the Department's Test Center in Colorado. The SOAC door width is 50 inches, which is sufficient to accommodate wheel chairs. Car floor level on the SOAC is adjustable by shimming to accommodate the range of transit property platform heights within plus or minus 1 inch. The SOAC incorporates an audible warning signal to indicate that doors are about to close. Public address systems announce station stops and when necessary emergency conditions. Stanchions and seatback handholds on the SOAC provide assistance in maintaining balance while walking or standing.

B. The advanced concept train cars, new rail rapid transit passenger carriers currently in the preliminary design stage, will address the problems of the handicapped and elderly. Currently four subcontractors are funded to perform a preliminary design and specification development effort. Each of the four subcontractors is performing tradeoff studies and analyses considering the needs of the handicapped and elderly. Provision incorporated in these cars will be the same as on the SOAC but will also include such factors as special space for wheelchairs, special seats, or special handholds, means for calling for and providing assistance and other new features.

C. In response to the National Capital Transportation Act of 1972, UMTA is conducting a study to determine the additional funds (if any) needed to make the facilities and services of the Adopted Regional System (Metro) totally accessible to the elderly and handicapped.

D. In Orlando, Florida a demonstration planning grant has been awarded which supports the design of a transportation demonstration program aimed at testing innovative transportation services for the elderly. Currently, the transportation needs of the elderly are being examined. Of the area's population, 14 percent are 65 years of age or older.

E. A study underway, sponsored by the Metropolitan Washington Council of Governments (COG) includes consideration of transit service for the handicapped and elderly. The needs of these groups are being specifically addressed in connection with proposed improvements to the existing transit system, new transportation systems, and subsidy and fare stabilization policies. This transit development program will build upon basic data studies which COG now has

underway, including a market survey to determine the special transportation services needed by the handicapped and elderly.

F. In Tampa, Florida, objectives of a planning grant include the needs of the aged and physically handicapped specifically in providing better services, routing and additional accessories to the current design bus.

G. A recently completed study by the Concho Valley Council of Governments (San Angelo, urban area) identified the elderly, handicapped and other low income persons as the major potential market for increased transit service in the area. Through a series of interviews, desired travel patterns were determined and route adjustments recommended. This study will result in increased services to provide these transit users with greater mobility in making trips between their residences and shopping areas, medical facilities, recreational activities, and other destinations.

H. Capital grants have been awarded to the cities of Alexandria, Louisiana; Modesto and Los Angeles, California; Fort Worth and Waco, Texas; St. Cloud, Minnesota; and Everett, Washington, to purchase buses with modifications to improve accessibility to the handicapped and elderly. Additonal stanchions will be added to the buses along with a hand rail around the fare box. The City of Winston-Salem, North Carolina has been awarded a grant to purchase modified buses and to change its bus routes to serve those neighborhoods with a large elderly population.

I. In an UMTA grant to Central New York Regional Transportation Authority, 10 of 97 new buses are equipped with front suspension that enables the front step height to be lowered from 14 inches to 8 inches for ease of access and egress. These buses will be used on routes which serve elderly and ambulatory handicapped housing areas. Under a Health, Education, and Welfare grant, special door-to-door service is being provided for the elderly and handicapped using one of these buses.

J. UMTA provided financial assistance to the Central Pinellas Transit Authority in Florida to purchase new buses which will be modified to be more accessible to the handicapped and elderly. These modifications include elimination of push-type doors; additional vertical stanchions in the aisles 30 inches apart; increase in width of aisles to 21 inches; lowered entrances so that the first step is no higher than 7 inches off the curb with successive risers no more than 8 inches in height; and treads no less than 11 inches in width.

III. Federal Aviation Administration (FAA)

In August of last year, FAA published an "Airport Medical Design Guide," which, if used in conjunction with a previously published advisory circular on eliminating barriers in airport terminal design, provides the airport operator with the necessary information for designing airports which are fully accessible to the handicapped and elderly.

IV. Federal Highway Administration (FHWA)

A. FHWA initiated a study to broaden its knowledge and understanding of pedestrian needs so that planning for pedestrians may be successfully integrated into highway transportation and environmental planning.

B. FHWA also financed a study to determine where present urban transportation systems are failing to provide adequate services so that these systems can be made more responsive to the needs of the transportation disadvantaged which includes the elderly.

C. An FHWA grant was awarded for the support of a study designed to make increased use of existing facilities for transporting disadvantaged residents of rural areas. The study will place special emphasis on solutions to transportation problems of elderly, handicapped, and poor people.

V. Federal Railroad Administration (FRA)

In its work with Amtrak, FRA has encouraged that design specification for new equipment include provisions to facilitate the movement of elderly and handicapped persons.

To the extent that FRA is involved in the design of railroad terminals, it encourages that steps be taken to ensure that adequate consideration has been given to the needs of the elderly and handicapped. For example, in a recently awarded contract for the design of a new suburban station in New Carrollton, Maryland, there is the requirement to incorporate facilities which ease the transportation problems of the elderly and the handicapped.

VI. National Highway Traffic Safety Administration (NHTSA)

During 1972, NHTSA undertook the development of an improved driver vision test device. Already completed has been the identification of visual performance requirements of driving and the relationship to visual functions such as glare recovery and dynamic visual acuity. NHTSA is currently developing a vision testing device which will discriminate among drivers as to their visual capability as this relates to the driving test.

SECTION FOUR: PLANS FOR FOLLOW-UP DURING 1973

The Department plans to undertake the following activities in behalf of the elderly during 1973.

I. Research and Demonstrations

Examples of research that will be carried out are:

A. One of the subtasks of a comparative analysis of urban transportation system alternatives is the examination of the worth of these system alternatives in meeting the needs of the elderly and handicapped and to estimate the cost and service impacts of any system modifications which would be required.

B. As a part of a larger study effort, the Department will compare system performance and cost characteristics in order to determine which transportation systems meet the needs of the elderly and handicapped. The cost of removing travel barriers will be reflected in the cost structure, and considered parametrically in the analysis.

C. Inasmuch as half of the urban accidents involving elderly pedestrians occur at intersections, a project is planned to determine safe and unsafe pedestrian behavior in pedestrians crossing the street, especially at intersections. In a later phase, countermeasures to avoid such accidents will be developed and tested.

II. Education

A. The Department, through its various administrations, will continue to work with the states to make transportation planners aware of the acute social and economic problems which are associated with limited mobility, and to encourage the planning and implementation of feasible solutions to mobility problems experienced by the elderly and handicapped.

B. The Department will continue to hold consumer hearings, which in the past have provided excellent opportunities for the elderly to discuss their transportation problems. Future hearings will be concentrated in rural and sparsely populated areas.

III. Cooperation With Other Federal Agencies, Administrations, Boards, and Commissions

A. The Department is expanding its working relationship with HEW to determine how resources of the two departments can be combined to improve the delivery of services to the elderly.

B. DOT will continue its efforts to rationalize fare structures during the current fiscal year. For example, in a January 9, 1973, filing before the Civil Aeronautics Board on Transatlantic passenger fares, the Department urged the Board "to permit the use of peak fares," but "to suspend and investigate the youth fares proposed." The Department again reiterated its opposition to fare structures in which "one group of passengers is expected to subsidize another class."

ITEM 12. DEPARTMENT OF THE TREASURY

FEBRUARY 6, 1973.

DEAR MR. CHAIRMAN: On behalf of the Secretary of the Treasury, we are pleased to furnish you with a report on the activities and programs of the Internal Revenue Service during 1972 on behalf of the elderly.

As in the past, we are deeply aware of the needs of our elderly citizens and plan to continue to expand in every feasible way the range of our service to them in the future.

If we can provide additional assistance to the Committee, please call upon us.

With kind regards,

Sincerely,

JOHNNIE M. WALTERS,
Commissioner.

[Enclosure]

INTERNAL REVENUE SERVICE ACTIVITIES AFFECTING THE AGED

Three areas in which the Internal Revenue Service has attempted to improve its service to elderly taxpayers during 1972 are: (1) improvement in individual income tax forms; (2) expansion of the taxpayer assistance training programs; and (3) extension of taxpayer service.

Improvement in Individual Income Tax Forms

The simplified Individual Income Tax Return, Form 1040A, was reintroduced for tax year 1972. This short form will reduce the burden on many elderly taxpayers from having to cope with the complications of the regular Form 1040 and its instructions. It is estimated that 30 million taxpayers (including 3.2 million persons age 65 or older) may elect to use this simpler 1040A form.

Moreover, the instructions for both Forms 1040 and 1040A have been carefully reviewed and simplified. A glossary of frequently used words and terms which may be unfamiliar to taxpayers has been added to the instructions. Another new feature is the inclusion of an order blank, with all tax packages, which will make it possible for older citizens, and other taxpayers, to obtain needed forms and publications by mail.

The improved instructions and order blanks, together with the emphasis on the Service's continuing offer to compute the retirement income credit on Form 1040, and the tax on both forms, for returns with income up to $20,000, should greatly reduce the number of aged taxpayers needing assistance in the arithmetic involved in computing their tax.

Taxpayer Assistance Training

During 1972, the Internal Revenue Service continued to expand its nationwide effort to provide tax assistance to elderly taxpayers. Institute training by IRS instructors in the preparation and filing of a Federal income tax return was given to numerous elderly and retirement groups and to individuals who later served as volunteer assistors to retired and elderly citizens. The training concentrated on special procedures and provisions of the tax law applicable to older persons and prepared the volunteers to help elderly people fulfill their tax filing requirements and to take advantage of the special benefits available to them.

The Service institutes offered approximately two days of training to 2,400 volunteer assistors, an increase of 100% over the previous year. Nearly 54,000 elderly taxpayers received tax assistance through the program in 1972, representing an increase of more than 250% over 1971. In addition, many more senior citizens received training this year, and, in turn, provided tax assistance to their contemporaries through the Volunteer Income Tax Assistance Program. Known as VITA, this project is designed to provide free tax assistance service to lower income, Spanish-speaking, and other disadvantaged people.

Much of the success of the volunteer tax assistance program for the elderly is due to the extensive cooperation between the Service and major retirement organizations. Again, this year, the Institute of Lifetime Learning (a service organization of the American Association of Retired Persons and the National Retired Teachers Association) was the leader among such organizations. Through their efforts in 1972, elderly tax assistance centers were established in major cities in 30 States. This program has been so successful that during the 1973 filing season, assistance centers will be available to elderly citizens in virtually every State in the nation.

Another way in which instruction is made available to senior citizens is through adult education programs co-sponsored by the Service and public school systems. Instructors from the Service provide tax instruction designed specifically for senior citizens on the preparation and filing of Federal income tax returns. Last year these sessions were attended by more than 20,000 persons.

A number of publications specifically tailored for the elderly can be obtained, free of charge, from District Offices and major subordinate offices. These include Tax Benefits for Older Americans (Publication 554); Tax Information on U.S. Civil Service Retirement and Disability Retirement (Publication 567); and Retirement Income Credit (Publication 524).

In a continuing effort to help Federal employees adjust to retirement years, additional copies of the instructor's guide for the pre-retirement counseling program, entitled "The Federal Income Tax Implications of Civil Service Retirement," were furnished to all Federal offices and departments. This instructor guide is used by agency retirement counselors to advise retiring employees of new

filing procedures pertinent to them and to provide information relevant to their changed status as taxpayers.

EXTENSION OF TAXPAYER SERVICE

In an effort to make tax assistance available to more individuals, the Service is staffing 350 temporary offices in shopping centers, post offices, and other locations during this year's filing period. Many of these offices, and our permanent offices, will be open later and on Saturdays. With the addition of Southern California and the States of Washington, Maryland, and Virginia, toll-free taxpayer service by telephone is now available in 30 districts, and will eventually be available nationwide. This service is of particular benefit to the elderly who are often less able or less inclined to travel to an Internal Revenue office to receive taxpayer assistance.

The range of assistance has also been expanded. The Service will provide any assistance necessary, and will even complete the returns of those taxpayers unable to prepare their own. Two additional services, being offered on a test basis in a few areas, are a pre-filing review and a mini-computer. The former entails a review of returns by the Service designed to pick up errors or omissions on returns before they are filed and thereby avoid extended processing delays that would otherwise occur. The mini-computer will, when fed appropriate taxpayer data, print out a complete Form 1040A, with a copy for the taxpayer, ready for signing and filing.

ITEM 13. FEDERAL TRADE COMMISSION

FEBRUARY 15, 1973.

DEAR MR. CHAIRMAN: I have asked my staff to prepare a response to your request for information regarding 1972 and projected 1973 activities of the Federal Trade Commission for inclusion in the report on "Developments in Aging."

In point of fact, the Federal Trade Commission is doing very little which is specifically directed at aiding only older people. But with characteristic enthusiasm, the staff has prepared a list of virtually everything the Commission is doing that could directly benefit consumers. They are convinced, and I believe rightly, that everything that benefits consumers is particularly beneficial to the aging.

As we are all aware, the aged are often particularly vulnerable to fraud and deception. I am confident that our efforts to enable the consumer to spend each dollar as wisely as possible are of great benefit to the aged.

I hope this letter is of some assistance and if we can do more, please let me know.

Sincerely,

MILES W. KIRKPATRICK,
Chairman.

HOW FTC PROTECTS OLDER AMERICANS FROM DECEPTIVE AND UNFAIR TRADE PRACTICES

The Federal Trade Commission has broad responsibility to protect older Americans, and other members of the public, from trade practices which are deceptive or unfair.

This responsibility derives from statutes which direct the Commission to investigate and prevent the use in commerce of unfair methods of competition and unfair or deceptive acts or practices; to prevent discriminatory and restrictive practices and dissolve mergers or acquisitions which tend to destroy competition or create monopoly in any line of commerce; to prevent false advertising of food, drugs, medical devices and cosmetics; to require fiber content disclosures on wool, fur and textile products; to prevent the sale of dangerously flammable fabrics; to require labeling of consumer products as to quantity of contents and origin; and to obtain credit cost disclosures and accuracy of credit reporting.

Actions of benefit to older Americans during calendar year 1972 included the following:

Issuance of a trade regulation rule effective July 3, 1972, on "Care Labeling of Textile Wearing Apparel," together with an educational leaflet, Buyer's Guide No. 10, explaining the rule.

Issuance of a trade regulation rule to require posting of octane numbers on gasoline dispensing pumps, effective March 15, 1972 (effective date deferred pending outcome of litigation involving challenge of Commission's authority to issue such rules).

Issuance of a trade regulation rule on "Cooling-Off Period for Door-to-Door Sales" (effective date to be announced).

Issuance of "Guides for Private Vocational and Home Study Schools" and proposed Statement of Enforcement Policy on "Cancellation and Refund Practices of Private Schools," plus action against individual schools for alleged misrepresentation of earnings potential.

Administration of the guides to prevent use of deceptive and unfair practices in the Hearing Aid Industry; issuance of orders requiring hearing aid manufacturers to substantiate their advertising claims, and announcement of intention to issue formal complaints charging use of anticompetitive practices by five hearing aid manufacturers.

Issuance for public comment of a revised proposed trade regulation rule on "Use of Negative Option Plans by Sellers in Commerce" (a form of selling commonly used by book clubs and record clubs).

Public hearings held regarding a proposed trade regulation rule on "Undelivered Mail Order Merchandise and Services," with record of hearings being evaluated at year end.

Acceptance of consent orders or assurances of voluntary compliance from several mail-order concerns which did not honor advertised guarantees of money back if not satisfied, failed to fill orders or make refunds promptly, used fictitiously high prices as a basis for advertised "savings," and misrepresented the quality and availability of merchandise.

Preparation of a revised proposed trade regulation rule designed to preserve consumers' claims and defenses in installment sales transactions and to protect consumers against the "holder in due course" doctrine.

Administration of new regulations effective January 1, 1972 under the Fair Packaging and Labeling Act to require truthfulness in representations with respect to "cents-off," "introductory offer," and "economy size."

Distributed educational material and lectured to consumer groups, including associations of aged persons, on the credit cost disclosure provisions and the right to rescind under the Consumer Credit Protection Act.

Distributed Buyers Guide No. 7 and Consumer Bulletin No. 7 on knowing your rights under the Fair Credit Reporting Act.

Distributed some 25,000 copies of Buyer's Guide No. 9 and Consumer Bulletin No. 9, "Protection for the Elderly."

Distributed a newsletter, "Consumer Alert," designed to keep consumers and consumer groups advised of current developments of interest.

Distributed other consumer education materials, including:

Buyer's Guide No. 1 and Consumer Bulletin No. 1 on the risks involved in purchasing "Mail Order Insurance."

Buyer's Guide No. 2 and Consumer Bulletin No. 2 regarding nonobligation of the recipient of "Unordered Merchandise."

Buyer's Guide No. 3 and Consumer Bulletin No. 3 on "Risks in Raising Chinchillas."

Buyer's Guide No. 4 and Consumer Bulletin No. 4 on "Franchise Business Risks."

Buyer's Guide No. 5 and Consumer Bulletin No. 5 on "Freezer Meat Bargains."

Buyer's Guide No. 6 and Consumer Bulletin No. 6, "Look for That Label," regarding fiber content disclosures on clothing.

Buyer's Guide No. 8 and Consumer Bulletin No. 8, "Don't Be Gypped," a description of common deceptions.

Educational Bulletin No. 1, "FTC Protects Consumers with Lab Tests," on testing wearing apparel fabrics for fiber content.

Educational Bulletin No. 2, "Cigarette Testing by FTC," to determine comparative tar and nicotine content.

Distributed general publications, such as "FTC—Protector of Consumers and Fair Competition," "Your Federal Trade Commission—What It Is and What It Does," and "List of Publications."

Distributed guides which command wide popularity among consumer groups, such as "Guides Against Deceptive Pricing," "Guides Against Deceptive Advertising of Guarantees," "Guides Against Deceptive Debt Collection Practices," "Guides Against Bait Advertising," and "Guide Concerning Use of the Term 'Free' and Similar Representations."

Administered the trade regulation rule, dated July 12, 1971, against "Unavailability of Advertised Specials," and announced an intention to issue formal complaint on such charges against one of the nation's largest food retailers.

Issued orders to prevent distribution of unsolicited credit cards, failure to disclose credit costs in advertising of loans by mail, bait advertising of freezer meat, health-imparting qualities of cookware, claims that caffeine-containing stimulant will improve sex life, misrepresentation of the costs and benefits of health club memberships, and false advertising as to nutritional value and caloric content of food.

Prepared a proposal for conducting a retail food price survey in selected metropolitan areas, to test the validity of claims by various food retailers that they sell at "discount prices" or "lowest prices."

Investigated reported use of unfair trading practices on the Navajo Indian Reservation.

Required disclosure of health hazard in print advertising of cigarettes.

Required advertisers to submit substantiation of claims with respect to debenture cleaners, cough and cold remedies, pet food, air conditioners, and automobiles.

Prohibited false advertising and failure to disclose credit costs in the sale of mobile homes, home sites, home improvements, furniture, carpeting, and new and used automobiles.

Prevented misrepresentation of guarantees and undisclosed sale of mailing lists by concerns engaged in preparing income tax returns, failure to disclose credit costs in the sale of life insurance, and misrepresentation of cost of magazine subscriptions.

Issued for public comment proposed guides to prevent deceptive use of endorsements and testimonials in advertising.

Stopped the sale of pajamas, carpeting and other products which failed to meet safety standards for flammability.

Examples of publications referred to above are enclosed.

The Commission during 1972 continued its program of federal-state cooperation, to encourage and facilitate the taking of corrective action at state and local level with respect to practices which, if used in interstate commerce, might be considered unfair or deceptive within the meaning of laws administered by the Commission.

The number of states with laws more or less like the FTC Act to protect the public against deceptive and unfair trade practices has grown to 40. The Commission from its headquarters and regional offices carries on an active liaison arrangement with consumer protection officials in those states, to provide prompt and effective law enforcement action at the lowest practicable level of government; and requests for information being received from the 10 states not having such laws indicate a likelihood of early enactment of such laws in those states.

The Commission during 1973 will continue to focus on paramount issues facing the nation's consumers, with emphasis upon unfair credit and credit reporting practices, misleading warranty contracts and failure to honor advertised warranties, abuses in door-to-door selling, deceptions in the sale of business opportunities and courses of vocational training, false advertising as to nutritional value and price of food, and deceptive or unsubstantiated efficacy claims in national advertising of over-the-counter drugs.

The Commission will continue to give priority to projects and actions which provide benefit to the widest possible numbers of the public, with older persons ranking in the top category of persons intended to be benefited.

ITEM 14. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

PROGRAMS FOR THE AGED—1972

The mission of the Health Services and Mental Health Administration (HSMHA) is to strengthen and improve the nation's health care delivery system. To this end, the Administration provides leadership and direction to programs and activities designed to improve general health services and mental health programs for the total population and strives to achieve the development of health care and maintenance systems that are adequately financed, comprehensive, interrelated, and responsive to the needs of individuals and families in

various socio-economic and ethnic groups. The goal is to make excellent health care readily available to everyone. The elderly, along with the rest of the population, benefit from program activities geared to meeting the health needs of all the people. At the same time, recognizing the special health needs of the elderly, many of the Health Services and Mental Health Administration's Programs are concentrating on special activities for this age group. Particular attention is being paid to the improvement of health services to the high-risk groups such as the institutionalized and the disadvantaged. Specific program activities and responsibilities and plans will be discussed under each program.

During 1972, special efforts were made within HSMHA to coordinate and make more viable activities related to and concerned with health services for the aged. The responsibility for coordinating all the Administration's activities related to the aging, long-term care and the Nursing Home Improvement Program was assigned to the Office of the Deputy Administrator for Health Services Delivery, and an Associate Deputy Administrator for Health Services Delivery (Nursing Home Affairs) was appointed to give direction to these efforts. Each of the Programs and the Regional Offices has designated a focal point for aging to facilitate coordination and communication. These persons are participating in several task force and work shop groups designed to accentuate the potential of HSMHA Programs for providing improved health services to the elderly and to enhance working relationships with other Federal agencies concerned with the elderly.

A Working Agreement between the Administration on Aging and the Health Services and Mental Health Administration was signed by the Administrators of both agencies in April 1972. This Agreement establishes a basis for joint working relationships between the two agencies to further the Departmental priority on aging which is to improve delivery of coordinated health and social services for older people and to provide a framework within which to structure joint efforts on consultations and sharing of expertise, coordination of planning and funding strategies, planning and implementation of service delivery programs, and recommendations for future program direction. Emphasis is being placed on the development of joint objectives which will further linkages between AoA- and HSMHA-supported programs at the local and regional levels.

Staff support is being given to follow-up activities of The White House Conference on Aging. Many of the recommendations of this Conference are being implemented through the various HSMHA Program activities. The broad activties directed towards the many heal th care needs of the elderly are discussed below.

NATIONAL CENTER FOR HEALTH STATISTICS

All health statistics prepared by the National Center for Health Statistics (NCHS) are or can be presented in terms of specific age groups. These have been summarized for the aging in a report "Health in the Later Years of Life."

Measures of morbidity among the noninstitutional population include the incidence of acute conditions and injuries, number of days of disability, prevalence of chronic conditions, and the number of persons whose activities are limited due to chronic conditions. The latter category is the measure of health status which increases most rapidly among the elderly.

These data from the household Health Interview Survey are usually presented for the broad age groups 45–64 and 65 and older so that some other characteristics which are related to both age and health can also be shown: family income, educational attainment, and living arrangements. Also reported in the interview survey are number of visits to physicians, medical specialists and dentists, episodes of hospitalization, days of hospitalization, expenditures for various types of health services, and sources of payment.

Health Interview Survey reports published in 1972 and which emphasize the aging are "Age Patterns in Medical Care, Illness, and Disability," "Home Care for Persons 55 Years and Over," and "Convalescence at Home Following Hospitalization Among Persons 55 Years of Age and Older."

The Health Examination Survey of smaller national samples of the noninstitutional population yields high quality diagnostic data on some of the chronic diseases most prevalent among older people—specific types of heart disease, hypertension, arthritis, visual and hearing defects, dental conditions. It also provides data on several physiological characteristics (height and weight, serum cholesterol level, blood glucose level, blood pressure) and on symptoms of psychological distress. In addition, current examinations include assessment of nutritional status. In this Health and Nutrition Examination Survey (HANES), the aging have been over-sampled to insure reliable statistics.

Separate surveys are made of the residents and patients in both long- and short-term care institutions—chronic disease hospitals, nursing homes, and general hospitals. These surveys provide data, classified by age and other characteristics, on utilization, diagnosis, medical and nursing care received and costs. "Charges for Care in Nursing Homes, a report from a recent Nursing Home Survey, was published in 1972 and includes data on coverage by Medicare and other types of medical assistance payments. Also published in 1972 and from the same survey were reports on "Employees in Nursing Homes" and "Services and Activities Offered to Nursing Home Residents."

Current activities include plans for a major national survey of 2,000 nursing homes with highly skilled employees. This survey will provide data on the operating costs of the homes and on the characteristics of employees on their staffs. In addition, data will be collected on approximately 20,000 resident patients in these homes. These data include socio-demographic characteristics, mental status, health status, assistance needed in performing activities for daily living, diagnoses, medical history and last examination, charges and source of payment, and any discharge plans. Pretesting of this survey will take place in February 1973, data collection in July-August 1973, and release of preliminary data in December 1973.

The National Center for Health Statistics also produces the national and state life tables and data on causes of death by demographic characteristics and geographic distributions of the population.

OFFICE OF THE DEPUTY ADMINISTRATOR FOR PREVENTION AND CONSUMER SERVICES

Center for Disease Control

The activities of the Center for Disease Control, in focusing on the preventive aspects of health services delivery and the quality of delivered services, protect and benefit the general public. Normally, these activities are not specifically targeted on the aging; but, because of their special health needs, this group is frequently reached with services. For example, the aging is one of the population groups with special nutrition-related health needs. Problem areas such as iron deficiency anemia could potentially be prevented by use of enriched foods. The Center has funded a demonstration project to determine the effect of food supplementation on health, through comparison of institutionalized and noninstitutionalized groups of elderly persons who have been supplied with nutritionally supplemented foods.

National Institute for Occupational Safety and Health

The National Institute for Occupational Safety and Health (NIOSH) is the principal Federal unit responsible for conducting research for new occupational safety and health standards governing exposure to on-the-job hazards. NIOSH was established by the Occupational Safety and Health Act of 1970.

NIOSH's extensive research program includes the conduct of industrywide studies aimed at determining the effect of long-term exposures to industrial materials, processes, and stresses on the potential for illness, disease, or loss of functional capacity in aging adults. The results of these studies will be published, the first of the series to be available in the spring of 1973.

NIOSH's industrywide studies focus on a variety of specific industries, ranging from asbestos workers to dentists and heavy construction workers. The studies are carried out on an in-house basis as well as through grant and contract mechanisms.

Bureau of Community Environmental Management

The functions of the Bureau of Community Environmental Management encompass a broad systems approach to the managemment of community and residential environments for the protection and enhancement of health and well-being. Emphasis is placed on the man-made or built environment as associated with the sociocultural aspects of human settlements. The Bureau's programs are oriented toward community organization for self-help.

Although the Bureau has no specific programs for the aging, consideration is given to this factor in the design of activities and programs for implementation at the community level. These activities include the development of housing and building codes and standards, building and fire safety standards for nursing homes, and research studies directed at the cause and prevention of burns, asphyxia, falls and accidents in general.

OFFICE OF THE DEPUTY ADMINISTRATOR FOR HEALTH SERVICES DELIVERY

Nursing Home Ombudsman Demonstration Program

The Nursing Home Ombudsman Demonstration Program was developed in response to President Nixon's August 1971 charge to HEW "to assist the states in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual patients" in nursing homes. Within HEW, the Health Services and Mental Health Administration was delegated the responsibility to implement this initiative.

A Task Force was appointed to study and plan the application of this approach to nursing home problems. It was soon identified as the ombudsman approach (the Swedish official known by that title having been traditionally associated with the resolution of citizen grievances). Representatives of all involved agencies within HEW, plus the Veterans Administration and OEO, composed the Task Force.

In its study, the Task Force indicated that in addition to providing an easily available mechanism for complaint resolution, ombudsman programs have great potential for identifying gaps and deficiencies in nursing home services, in stressing the accountability of nursing homes for quality of care, in stimulating the self-reliance of patients and their families in securing better care, and in promoting communication and coordination among regulatory and service agencies.

Since the application of the ombudsman principle in the nursing home field is a new experience, the Task Force recommended demonstration and evaluation in order to determine the effectiveness and appropriateness of various approaches to providing ombudsman services. The major distinction between approaches was concerned with the auspices under which the demonstrations would be conducted, i.e., state government or a voluntary organization of senior citizens. Guidelines for proposals to implement each of the models were prepared, and all state governors and many national voluntary organizations were requested to indicate their interest in submitting proposals. Proposals were evaluated by members of the Task Force. The major technical criteria used were the adequacy of the plan to implement the project and the ability of the project to operate objectively and independently.

On June 30, 1972, five contracts were awarded for the establishment of Nursing Home Ombudsman Demonstration Projects. Four of the contracts are with state governments to establish a state-level office linked to a local-level unit. The States are Idaho, Pennsylvania, South Carolina and Wisconsin. The projects are located in agencies which are not responsible for the regulation of, or services to, nursing homes, in order to permit operational independence and objectivity.

The fifth contract is with the National Council of Senior Citizens, a national voluntary organization, for the establishment of a national-level Nursing Home Ombudsman Office linked to a state-level and two local-level units in Michigan. This project relies heavily on the use of volunteers in complaint receipt and resolution and should provide interesting comparisons with projects conducted under state auspices.

The primary task of each of the projects is to establish an effective, viable mechanism for complaint receipt and resolution. In addition, each will document and communicate broad issues requiring system changes in the regulation of institutions and services to long-term care patients.

Much of the first phase of operations has been devoted to recruiting and training staff, establishing policies and procedures, and building working relationships with regulatory and service agencies, and with community groups interested in the needs of nursing home patients. Each of the projects has been successful in establishing cooperative relationships with State Health and Welfare Departments, regional HEW agencies responsible for nursing home standards, and with nursing home operators. The remainder of the contract year will be devoted to the provision of ombudsman services to patients and their families. Depending on availability of funds, it is anticipated that the five contracts will be renewed for a second year of operations.

Evaluation of the demonstrations is an integral part of the program. Assessment of the effects of location and auspices of the projects, modes of operations, differential use of staff, linkages with agencies and community groups will provide valuable knowledge which can be used by other states or organizations in providing similar services.

This program is located in the Office of the Deputy Administrator for Health Services Delivery.

COMMUNITY HEALTH SERVICE

The Community Health Service stimulates, conducts, supports and evaluates programs designed to increase the effectiveness and efficiency of allocating and utilizing health resources for quality preventive and curative health services obtainable and acceptable to the American people. To this end, the Service promotes, develops and supports: (1) programs of health care focused on the needs and entitlements of individuals and families wherever they live, but with special emphasis on health services scarcity areas; and (2) standards and evaluative activities as a means of increasing the nation's capacity for delivering quality health services.

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 or specially adapted to meet these needs.

LONG-TERM CARE PROGRAM

Aging and long-term care

A reorganization of the Community Health Service in October 1972 placed a greater focus on aging and long-term care through the creation of an Office of Long-Term Care Services in the Division of Health Care Services. The newly created Office carries out the following functions: (1) serves as focal point for testing methods to improve long-term care and translates improved methods into operation of direct health care projects; (2) develops methods to integrate general health care services with long-term care institutions; (3) provides leadership and coordination for the planning and development of programs in long-term care education; (4) maintains liaison with Federal, state and non-governmental organizations and agencies concerned with extended care facilities, nursing homes, home health agencies, hospitals and programs for the aging; and (5) identifies gaps in existing authorities to meet priority needs of the elderly and develops suggestions, plans or legislative specifications for inclusion in Office of Long-Term Care Services, Division of Health Care Services and Community Health Service long-range plans and legislative proposals. These functions are carried out in the Office of the Chief, and in the three Sections: Nursing Homes and Institutional Services Section, Ambulatory and Home Health Services Section, and Long-Term Care Education Section. To implement the program in the Regions, a Long-Term Care Education Coordinator has been appointed in each of the 10 Regional offices to serve as lead Regional staff in coordinating, communicating, working directly with the Federal, state, local, and professional and medical associations who play a part in the short-term training effort.

New strategies for long-term care

During the latter part of the year, attention was given to the nature of services relating to long-term care of the elderly in the direct health care programs of the Community Health Service. It was obvious that a serious hurdle was the lack of reimbursement for long-term care available through such centers and in the home. This led to a reordering of priorities to place special emphasis on the development of strategies to expand and improve long-term care in ambulatory care settings. Such settings include neighborhood and family health centers, health maintenance organizations, and outpatient departments of public hospitals. An example of such special efforts is a contract with the Atlanta Southside Comprehensive Health Center: "A Demonstration of the Development of Home Health Services through a Neighborhood Health Center and Total Community Effort."

Short-term training

As part of President Nixon's national program for improving the quality of care in nursing homes, DHEW was directed to institute a program of short-term training for nursing home personnel; and the Community Health Service was designated as the lead agency for implementation of this directive. Within CHS, prime responsibility for carrying out this function was assigned to the Office of Long-Term Care Services; and this activity was given priority status.

During 1972, several approaches were taken to implement the President's initiative in short-term training for nursing home personnel.

Seven statewide programs were developed for multidisciplined training activities designed to provide a wide range of training approaches and to demonstrate the value of new methodologies for all categories of nursing home personnel. Contracts were awarded to the following states or organizations: University of Alabama; State of South Carolina; Colorado Health Care Association; University of

Pittsburgh; Iowa Nursing Home Association; State of Ohio; Minnesota Nursing Home Association.

The following national professional organizations were awarded contracts to develop training programs on a nationwide basis: American Nursing Home Association, to train 10,000 personnel who work in nursing homes in ways to expand, develop and enrich the lives of nursing home patients; the American Medical Association, to train 300 nursing home medical directors and 300 nursing home administrators to work as nursing home medical directors and to upgrade the abilities of physicians who already hold such positions; the American Nurses' Association, to train 3,000 registered nurses in geriatric nursing; the Association of University Programs in Hospital Administration, to develop and test in-depth training curricula for nursing home administrators. Contracts were also awarded for the development of audio-visual programmed instructional materials for the training of nursing home personnel, and for the evaluation of the effectiveness of all the short-term training contracts.

Professional education

A comprehensive body of knowledge in applied gerontology was developed and made available to the public by CHS as a training resource in the form of a series of publications entitled "Working with Older People: A Guide to Practice." These volumes are: Volume I, "The Practitioner and the Elderly"; Volume II, "Biological, Psychological, and Sociological Aspects of Aging"; Volume III, "The Aging Person: Needs and Services"; Volume IV, "Clinical Aspects of Aging." All four volumes continue to be in heavy demand for use not only in short-term training programs but in undergraduate as well as graduate teaching programs.

In-home services

Expressions of interest in the potential of in-home services have been increasing in all areas of our health and welfare systems. They are stressed as an "alternative to institutional care" in health programs, and as an essential component in ambulatory care systems. They are repeatedly referred to as the most needed service for the aging population, for the chronically ill, for the disabled. These expressions of interest have produced a variety of approaches, many of them underlining or demonstrating the potential value of such services. They have not yet produced a national policy.

Significant events in the promotion, development, and expansion of home health services by CHS during 1972 follow.

Assistance was provided in the preparation of the Report to the Special Senate Committee on Aging by Brahna Trager, entitled "Home Health Services in the United States" (April, 1972). The report served as a springboard for a national expert meeting on "In-Home Services—Toward a National Policy," held on May 31–June 2 where the following key recommendation was made: "In order to insure the right of individuals to live a full life in the place of their choice, we recommend that the top national priority be given to the development of a rational system of comprehensive in-home services with emphasis on the prevention of illness and disability (Physical, mental and emotional) and the promotion and maintenance of health. A crucial problem which this program should be designed to avoid is the unnecessary displacement of persons because of lack of services."

As an outcome of this conference, a two-day working conference, on "Comprehensive Health Planning in Home Health Care" was held in Charlottesville, Virginia, on August 28–29 under a purchase order with the University of Virginia. The 33 participants who represented various disciplines included planners, providers and third-party payors.

The above two conferences will produce proceedings which are being prepared and will be distributed by the Office of Long-Term Care Services early in 1973.

All but two of the ten Regions have dealt with the broad concepts of community planning and organization of home health services and also specific patients problems such as discharge planning and continuity of care through the conduct of numerous conferences and training workshops.

In the past year, special emphasis has been placed on data collection. A special home health agency encounter form was developed to collect data on the functional evaluation of the patient, the care given, and the costs related to such care. In addition, efforts are being made to develop a problem-oriented medical record for use in home health agencies. An inventory of the basic in-home services is being conducted under contract with the National Council of Homemaker-Health Aide Services. Technical materials developed during the year include

two basic documents dealing with the planning, organization, and operation of home health service programs and a publication directed to families of the elderly on care of the older person in the home; all of these publications will be available early in 1973.

Related programs

Consideration is being given to the development of Day-Care Centers for the infirm elderly as an alternative to institutional care. A state-of-the-art paper on Day Care has been developed for the Office of Long-Term Care Services, and plans are underway for the OLTCS to sponsor a Conference on Day Care to be held early in 1973. This conference will bring together representatives of ongoing Day-Care programs along with representatives of newly developing programs for an exchange of information.

The effectiveness of health maintenance in housing for the elderly as an alternative to institutional care is being investigated. A state-of-the-art paper on this service in housing for the elderly in Rhode Island is currently in preparation, and future efforts will be directed at determining the feasibility of developing such services in conjunction with existing health services delivery systems such as neighborhood health centers and family health centers.

COMPREHENSIVE HEALTH CARE SERVICES

Along with his concern for improving nursing home care, the President assigned a high priority to the development of alternatives to institutionalization for the elderly. In his address to the White House Conference on Aging in December 1972, he said: "The greatest need is to help more older Americans to go on living in their own homes." Among the services needed to maintain an individual in an independent state are many that relate to social and economic factors. Basically a foundation of comprehensive health services (provided in ambulatory care settings or in the home), available and accessible to all older persons, should be provided by all communities.

Ambulatory care

Through its Division of Health Care Services the Community Health Service has focused on the development of systems of ambulatory care for complete target populations including the elderly.

Neighborhood and Family Health Centers

To date 67 health centers have been developed, aimed at a target population of about 1.2 million persons. The range of services delivered includes: preventive services and health maintenance; emergency services, screening and diagnostic services; treatment services; dental care; rehabilitation; home care; immunization; pharmacy; social-services and outreach programs; hospital referral.

Data gathered from a sampling of health centers during the latter part of the year pointed to an apparent underutilization by the elderly of some of these health centers, but revealed a high utilization of services by those elderly who came to the centers. Specifically, data from quarterly reports of a sample of nine health service 314(e) projects revealed the following: 6.4% of the registered population of the sample group were over 65; 8.3% of the actual users of the sample group were over 56; during the sample quarter, 7.0% of all those who had one encounter were aged, 10.0% of all those who had two encounters were aged, 13.1% of all those who had three encounters were aged, 11.5% of all those who had four encounters were aged, and 16.3% of all those who had five or more encounters during the quarter were aged. Thus it is significant that the aged, although representing only 6.4% of the registered population from this sample group, account for a much higher percentage of the utilization of services from the 314(e) projects.

Migrant and Rural Health Services

The Migrant Health Act authorizes provision of health services to the agricultural worker and his family. As a group, the migrant family represents an underserved segment of our population in terms of most social and health services. The elderly migrant, generally uneducated, often unable to speak English, living in remote rural areas with no access to social services, suffers from an even more intensified lack of services. In addition, the elderly person who is no longer able to participate in the work force, may find himself left behind in a home-base area as

the rest of the family travel north for three to seven months of the year looking for work.

Of the 259,000 migrants who receive medical care under funds from Section 310 of the Public Health Service Act, 3,000 are over 65 years of age. Most of them are women who are traveling with the families, serving as baby-sitters for their grandchildren and doing domestic chores for the family as needed.

The Migrant Health Program will continue to emphasize increased development of personal health services for migrant farm workers and their families.

Within the often limited availability of local resources, arrangements are made by project workers for in-patient hospital and nursing home care for migrant seasonal farm workers and their families.

MEDICAL CARE STANDARDS

When Medicare was enacted in 1965, the Secretary of HEW was required to establish national conditions of participation 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, particularly for long-term care facilities, home health agencies, and independent laboratories. Qualifications required for many types of health care manpower also were inadequate to ensure a safe level of quality of services. The Division of Medical Care Standards, working with the Social Security Administration, was assigned principal responsibility for standard-setting and surveillance of the program, and for other professional health aspects of Medicare of direct benefit to program beneficiaries.

The objective of the Division of Medical Care Standards is the improvement of the health status of Medicare and Medicaid beneficiaries by ensuring that the types, quality, and quantity of services provided under the program are appropriate to patient needs. Since the onset of the 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 qualifications and availability have proved difficult. However, Medicare has helped to focus attention on problems of health manpower—from physicians to nurse aides—including their supply and the surveillance of the services they provide. Various techniques, for assuring quality of services without unduly limiting the supply of health care personnel, including the utilization of proficiency examinations for selected categories of such personnel, are undergoing study and experimentation; and Medicare, through the Division of Medical Care Standards is in the forefront of these efforts.

Currently, the conditions of participation for providers of services are being totally revised. This is the first complete revision since the original conditions were implemented more than five years ago. The Health Insurance Benefits Advisory Council has approved revised conditions and is soon to consider the new single set of regulations to cover skilled nursing facilities (formerly skilled nursing homes under Medicaid, and extended care facilities under Medicare) as mandated on passage of the Social Security Amendment of 1972 (Public Law 92–603). When these have reached the regulatory stage, the Division of Medical Care Standards will assist the Bureau of Health Insurance in the revision of guidelines and survey report forms required for implementation of the revised standards.

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 quality assurance mechanisms including 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 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 was nonexistent prior to Medicare. The Division has been the principal proponent in establishing medical care evaluation studies, a mecha-

nism for evaluating the quality and effectiveness of health services, as an integral component of the Utilization Review process. 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.

Another ongoing comprehensive program instituted in 1970 was to improve the interpretation and uniform application of Federal health care programs by state agency personnel through training and evaluation of individual surveyor performance. This program was developed to meet a specific need following the enactment of Medicare and Medicaid, and has been supported by the states, the Social Security Administration, and the Social and Rehabilitation Service, all of which have assisted in its development. The health facility surveyors who are being trained through university-based courses have a major responsibility for ensuring that nursing homes, extended care facilities, hospitals, and home health agencies provide safe and adequate care and comply with required standards in serving Medicare and Medicaid beneficiaries.

In Chicago on June 25, 1971, in remarks to a Joint Conference of the National Retired Teachers Association and the American Association of Retired Persons, the President referred to the "depressing" nature of some nursing homes. In August he announced a Plan for Action to improve the quality of care provided in the nursing homes of our country, as a result of which the Federal Program (Health Facilities Survey Improvement Program) was expanded to provide training for 2,000 state nursing home surveyors. Since the inception of the program 774 state surveyors and 143 Federal employees have completed the courses.

Still another way in which the Division has a relationship to the health services for the aged is by recommending changes in Medicare policies and legislation, and in conducting studies. Some of these recommendations and studies have directly affected the accessibility, quantity, and quality of care in the Medicare program.

The Division will play a focal role in implementing the Medicare-related Social Security Amendments of 1972, with emphasis on Professional Standards Review Organization and Medicare-Medicaid state agency coordination, and in providing professional support in administering the additional benefits contained in this legislation.

In all of these activities, the focus of the Division is the health and safety of Medicare's elderly beneficiaries. Its operations, planning, and evaluations are directed specifically toward this focus.

RELATIONSHIPS WITH OTHER AGENCIES

The Office of Long-Term Care Services Central Headquarters staff and Long-Term Care Education Coordinators in the Regional offices, working in concert with the Office of the Administrator, HSMHA, have provided on a continuing basis technical consultation to the Administration on Aging in the development of the Areawide Model Projects relating to alternatives to institutional care. Consultation has also been provided to other component programs of Social and Rehabilitation Service and the Social Security Administration concern with health and health-related programs for the elderly.

Staff members of the Office of Long-Term Care Services also provided consultation and participated in activities sponsored by the Veterans Administration, including the planning and conduct of conferences on alternatives to institutional care and planning for a series of seminars on orientation of health practitioners on the subjects of the continuum of care, dying and death. The Veterans Administration has developed a teaching film based on a monograph in the HSMHA publication, "Clinical Aspects of Aging"; production of a second film based on another monograph in the volume is under consideration.

Technical consultation has been provided to HUD on health maintenance needs and services in housing for the elderly.

In response to requests from voluntary and professional organizations and educational institutions, CHS staff have served in faculty and resource capacities in a broad range of programs relating to health services for the elderly.

INDIAN HEALTH SERVICE

The Indian Health Program serves 475,000 Indians and Alaska Natives living in geographic and cultural isolation on 250 Reservations and in Indian communities located in 24 states, including hundreds of villages in Alaska. Based on the

1970 U.S. Census statistics, persons aged 65 and over represent approximately 6 percent of the U.S. Indian and Alaska Native population; therefore, the Indian and Alaska people are a young segment of the U.S. population.

The approximately 27,500 aged 65 and over and the 61,200 persons from 45 to 65 years, within the Indian Health Service population are reached through comprehensive health care provided through the Indian Health Service system of 51 hospitals, 84 field health centers, over 300 health stations located in the vicinity of Indian family groups, and through a contract medical care program. These health and health related services covering the life span of this service population have resulted in a decline of death rate of Indian Health Service beneficiaries by 15 percent from 1960 to 1971.

In order to best utilize scarce resources to meet the many health needs of all of the 475,000 Indian Health Service population, program emphasis is directed to those in the younger age group. While attending to the health needs of the elderly, a major objective of the Indian Health Service is to advance the health level of the young and to maintain their health gains thus achieving a larger older age segment of the population with improved health status.

Specific services provided by IHS, which minimize the health problems of the aged and aging include:

Identification of the aging and aged and their problems by all members of the IHS staff in the course of day-to-day operations throughout Reservations and Indian communities;

Coordinated services of the IHS physician, nurse and social work staff in meeting immediate health and social problems, preventing crises and future problems and maintaining the health gains of the elderly;

Social assessment of the needs of the family and the lone elderly which recognizes the changing roles, functions and status of the elderly, and social planning to meet their needs;

Services of the IHS-trained Indian and Alaska Native Social Work Associates who provide a full range of social work services to their people while advancing their social work careers; these native social workers further help the elderly to interpret the differing cultural concepts of "well" and "sick" and to seek health services early;

Development of the Indian Physician Assistant and Training Program which will extend outreach Indian health services to the elderly;

Assistance by the IHS-trained Indian Community Health Representative and the Alaska Native Community Health Aide, especially in seeking out the elderly and bringing their individual problems to the attention of appropriate health and social resources, providing transportation to IHS facilities and spanning the language and cultural gap between elderly Indian patients and non-Indian professional staff when needed;

Provision of Public Health Nursing services to 3,210 individuals or more than 13 per cent of the Indian service population aged 65 and over; a total of 10,650 visits were made to this group or an average of over three visits to each person; nursing consultation is provided to nursing homes on behalf of Indian patients, the majority of whom are elderly;

Counseling by IHS pharmacists to patients, mainly the elderly, with chronic diseases such as diabetes and heart disease, on long-term drug therapy, who are given priority for instruction relative to the correct use of drugs and medications, and to assist the patient in understanding what to expect in results from the appropriate use of drugs;

Prevention of institutionalization of the senile and mentally ill elderly through mental health treatment and alternative social planning;

Contract health services within the funded scope of this IHS resource, including nursing home and extended medical care;

IHS medical and social service surveillance for nursing home and extended medical care patients;

Improving income levels of the elderly through application assistance for state and Federal program benefits;

Assisting the elderly to obtain services under such programs as Medicare, Medicaid, and Veterans' programs;

Environmental Health Services concerned with safe water supplies and waste disposal systems, vector control, home sanitation and safety, and correction of environmental conditions which adversely affect the physical and social environment of the elderly as well as the general public; nutrition and dietetics family-centered service program of intensive education, adapting proper principles to the food habits and cultural practices of the Indian and Alaska Natives; the

elderly are reached within these services for the family and special emphasis given to improving nutritional health; individual income and nutritional quality of diet are related; information regarding the USDA-administered food assistance programs (food stamps, commodities and supplemental foods) is provided to as many of the aged as possible, with special attention directed to the best possible use of these resources to improve the overall nutritional status; nutrition consultation is provided to USDA and other agencies working with Indians and Alaska Natives on educational activities and in group feeding programs;

IHS consultant services relative to improved and new housing for the elderly; IHS consultant services to tribal groups on all phases of planning nursing home construction and operational management and services;

Assisting tribes in the identification and use of all community state and Federal financial program services needed to attack special problems affecting the aging and aged, such as grants for alcoholism and nutrition projects, and resources for the development of Home Health Aide-Homemaker Services;

Health education services directed toward Indian communities, tribal groups, families and patients including the elderly to assist the Indian people to use the IHS health care system, to understand the disease process and to take preventive measures which will ensure good health;

Training Indian Health Boards in the art of program planning, financing and operational management of the IHS.

Federal Health Programs Service

The Federal Health Programs Service has no programs which of themselves relate directly and specifically to aging. This applies to its research and clinical care programs as well as to the programs of Emergency Health Service and Federal Employee Health. For FY 71, of a total of 35,276 discharges from hospitals of the FHPS, 3,959 were over 65. The average length of stay for elderly men was 21.4 days and for elderly women was 21.0 days, compared with an average length of stay of 16.9 days for all patients. Consistent with this finding is the fact that older patients are affected to a greater extent by chronic conditions which require longer periods of hospitalization; and for similar conditions, older patients tend to receive longer periods of hospital care than younger patients.

A high proportion of elderly persons receiving in-patient services are American Seamen, who constitute the primary beneficiary group cared for in PHS hospitals. The problems presented by this group of patients are similar to those presented by aging patients in general, with one exception: there are probably more single males in this group than in the general population. Because of this fact, finding suitable nursing homes for their long-term care constitutes one of the real problems in meeting the needs of aging patients served by FHPS.

National Health Service Corps

While there are no activities specifically earmarked for the aging, some general comments about the relationship of the program to the aging can be made.

The Corps' activities are directed to areas which are "critically short" of health personnel. While it is difficult to generalize, these areas are usually of two general types—urban inner cities or remote rural areas. Both of these types of areas have heavy concentrations of older persons who either cannot move elsewhere or do not wish to do so. The guiding principle behind the Corps is the idea that simple residence in a certain type of area should not by itself be a barrier to effective health care. By assigning its personnel to such areas, the Corps hopes not only to alleviate the immediate health care needs of the target populations, including the elderly, but by so doing to make such areas more attractive places to live for the long term.

It is not possible to project at this time what proportion of the Corps' services will be provided specifically to the elderly. However, such data will be collected in an effort to develop more effective methods for reaching these populations. The Corps will devote much attention to the problem of developing effective outreach systems for getting care to those who need it; certainly the elderly are particularly in need of such outreach. The Corps will work closely with organizations of and for the elderly wherever it can, drawing on them as other community groups, for support and assistance. It is a cardinal rule of the Corps that its services are designed by and for the communities involved. Since the elderly form a large proportion of the population in many of the areas, it is expected that they will play a major role in Corps' activities.

OFFICE OF THE DEPUTY ADMINISTRATOR FOR DEVELOPMENT

National Center for Health Services Research and Development

The role of the National Center for Health Services Research and Development (NCHSRD) in long-term care for the elderly is part of a positive coordinated response by the Office of Nursing Home Affairs in the Office of the Assistant Secretary for Health to the President's stated purpose on August 6, 1971, to move toward the goal of improving quality of life for the aged.

The efforts of NCHSRD have been channeled down three avenues:

1. Implementation of Long-Term Care for the Elderly Research Review and Advisory Committee (LTCERRAC) whose purpose is to:
   (*a*) Provide a coordinated professional technical review of proposals submitted to DHEW concerning long-term care for the elderly; and
   (*b*) Identify problems and issues and develop a tentative ordering of priorities in long-term care for consideration by the Office of Nursing Home Affairs in the Office of the Assistant Secretary of Health
2. Development of a strategy for research in cooperation with the LTCERRAC; and
3. Initiation of directed research projects using the grants and contracts mechanisms.

During fiscal year 72, the NCHSRD initiated a program of directed research focusing on long-term care for the elderly. Projects of this program will continue through fiscal year 73, along with new projects to be initiated in fiscal year 73. Research and development funds were allocated from the fiscal year 72/73 supplemental appropriation designated for the Nursing Home Improvement Program. Projects were funded employing both the contract and the grant mechanism as appropriate to obtain the desired directed research which addresses measurement of the quality of long-term care, alternatives to institutional care, and data systems for planning and managing quality care programs for the elderly. Each research and development project supported by NCHSRD is intended to produce results that can be tested and evaluated on a national scale.

Projects initiated during fiscal year 72 have been programmed and selected, using the peer review mechanism, to provide the best possible utilization and application of research findings. For example, two projects have been funded that are concerned with the development of indices for quality of care. One project is short-range (8 months) and is designed to assemble and pilot test objective scales for measurement of quality of care in nursing homes. A significant research effort has been expended in recent years to develop workable scales to assess objectively, facility environment, patient needs, and patient placement. These efforts, however, served their separate purposes at different times and were not interrelated. The purpose of this contract is to synthesize past efforts into operationally useful instruments for objective measurement of quality of care. A longer range project has also been funded to develop and demonstrate a system for assessing the status of long-term care patients so that their social, psychological, and physical needs are met most effectively. The two projects described complement each other and. through an established Design Advisory Group, results are shared.

NCHSRD will also attempt to emphasize utilization of research from other projects in long-term care. For example, an on-going 3-year developmental project directed at the investigation of the premise that a medically based determination of the care needs of the chronically ill and aged results in higher percentage of appropriate placement. Findings to date show that at least 25 percent of beneficiaries are now utilizing appropriate services, resulting in a potential savings of approximately 10 percent to the Medicaid program.

NCHSRD is integrating its strategy of research and development in quality of care of the aged with other quality assurance research programs, such as the Experimental Care Review Organization (EMCRO). The Experimental Health Delivery Systems projects and the Federal-State-Local Data Systems projects also offer opportunities for integrating and utilizing research concerning long-term care for the elderly.

NCHSRD is sponsoring six projects funded under the Nursing Home Supplemental Appropriation. Some of these will continue into FY 73 and 74 and will dovetail with other long-range research and development projects previously initiated by NCHSRD. For example, one long-range innovative project, building on previous research and development work, is demonstration and evaluation of a mobile "chronic disease module." This is intended to increase the community's capability to provide unbroken care to its chronically ill,

especially where services are nonexistent or weak. This project includes defining and training new categories of manpower to function as health assistants. Another manpower development project culminating in FY 74 is the evaluation of the Family Nurse Practitioner Program (PRIMEX), where attempts are being made to measure the effects of the expanded role of the nurse on patient satisfaction, the quality and comprehensiveness of health care provided, and the cost of providing the care to an elderly population.

As the results of these programs emerge, new areas for research will become apparent. FY 74 projects will deal with expanded assessment of measurements of quality of care and life; development of interlocking data sets representing different levels of care; through documentation of the cost-effectiveness of ongoing and experimental alternatives to institutionalization; and precise role specification for various types of manpower. Additional emphasis will be placed on population studies examining patterns of needs and survival strategies of the elderly. Knowledge of existing patterns of needs and needs fulfillment is seen as essential to the rational planning of services in a rapidly changing and complex industrial society.

Health Care Facilities Service

A primary objective of the Health Care Facilities Service, which administers the Hill-Burton Program, is to stimulate the construction and modernization of facilities needed to bring about an efficient, well-coordinated network of health services for all persons, including the aged and aging.

With the enactment of the Hospital Survey and Construction Act of 1946 (Public Law 79–725), grants were made available to the states to assist in constructing, equipping and modernizing nonprofit privately and publicly owned hospitals and public health centers. Over the years, various amendments to the original legislation have changed the scope of the Program to encompass other categories such as long-term care and outpatient facilities. Most recently, the Medical Facilities Construction and Modernization Amendments of 1970 (Public Law 91–296) further broadened the Program to include loan guarantees with interest subsidies for nonprofit hospitals and direct loans for public hospitals to aid in modernizing or constructing health care facilities.

As of January 1973, the Hill-Burton Program had provided assistance for the construction of 99,400 long-term care beds in nursing homes, chronic disease hospitals, and long-term care units of general hospitals. These 1,769 projects, which primarily meet the needs of our aged population, accounted for $537 million of Hill-Burton funds, or 14 percent of all funds expended during the life of the Program.

Our aging and aged also extensively utilize the other health facilities being constructed or modernized under the Hill-Burton Program—hospitals, outpatient facilities, public health centers, and rehabilitation facilities. With high priority currently being given to the expansion and improvement of outpatient care services for all age groups, nearly half (47 percent) of the projects approved for grant funds, during FY 72 were for the construction or modernization of public health centers outpatient facilities, and rehabilitation facilities.

With the aged population continuing to increase, there is still a substantial need for additional long-term care facilities. Hill-Burton State Agencies report 910,000 beds existing in nursing homes, long-term care units of hospitals, and chronic disease hospitals; 70 percent, or 647,000 beds, are classified by the states as conforming to minimum Federal standards of construction and patient safety. The state agencies estimate that more than 350,000 additional long-term care beds, including extended care facility beds, need to be constructed, remodeled, or replaced.

Other activities of the Health Care Facilities Service which benefit the aged include seminars and workshops for the administrators and staff of health care facilities such as nursing homes. Technical consultation is provided in a variety of areas affecting aged patients—fire safety, infection and environmental control, nursing care and dietary services. In addition, the following publications relating to long-term care facilities are in process: (1) a prototype design for a 100-bed skilled nursing home which is being developed primarily for use by architects desigining such facilities; and (2) functional programing guidelines and equipment and design options for extended care facilities.

Comprehensive Health Planning Service

Comprehensive health planning concerns itself with the total health needs of all the population. As of January 1973, there were 56 state agencies and 198

areawide agencies. The latter covered 70 percent of the population and the former the entire population.

The comprehensive health planning programs were established under P.L. 89–749 and are continued under 91–515. The Comprehensive Health Planning Service has been part of the ongoing HSMHA activity on aging and has, during the year, participated in the Task Force on State and Local Programs under the Older Americans Act of 1965.

The broad concern of comprehensive health planning and the freedom of choice allowed in actual operations has led to a great variety of activities including many having to do with the health needs of the aging.

A telephone survey was made in January 1973 to find examples of the types of activities being carried out on aging by comprehensive health planning agencies. Seventy-one examples were reported of which 14 were state activities. Some of the examples included several types of planning activities and advocacy action areas. They were tabulated to reflect their multiple nature. The type planning functions and activities reported included 31 surveys or studies of which publications were reported for 11; 28 coordination or linkage activities; 17 agency committees or task forces with eight reporting priority-setting functions and six reporting written plans on aging topics. The advocacy action areas reported included 10 on health facilities, 11 on health services, six on housing, two on coordination and referral, two on legislation and two priority activities on getting patients out of mental institutions and into homes.

Regional Medical Programs Service

Great impetus has been given to health care of the American people by the focus of the Regional Medical Programs on accessioility, efficiency, efficacy and high quality of care. Consortiums of providers and consumers have come together to plan and implement health activities to meet needs which, over time, have not been assumed by individual practitioners, health professionals, hospitals, and other institutions and organizations acting alone. A network of 56 individual RMP's promotes and demonstrates new techniques and innovative delivery patterns; supports training which results in more effective utilization of health manpower; and encourages the regionalization of health facilities, manpower and other health resources.

Instead of concentrating on the application of glamorous new techniques to the treatment of a few people, standard medical treatment should be made more widely available to a greater number of people who do not have access to care or who receive inadequate care. Working on this premise, the local RMP's regard themselves as agents of change whose purpose is to bring about significant improvement in health care delivery programs. This is accomplished by working cooperatively with all groups involved in health services. It involves a behind-the-scenes role in promoting quality, quantity, and efficiency of medical care. A major goal of the RMP's is to provide support to health care projects and to promote cooperative arrangements among health care services in the local jurisdictions. Therefore, the RMP's are potent forces for bringing about and assisting with changes in the provisions of personal health services and care, prevention of possible duplicative efforts, and training of personnel to meet the need as locally determined, and as an integral part of the total comprehensive health services.

Originally initiated as a program to attack heart, cancer, stroke and related diseases, the Regional Medical Programs Service has broadened its concerns and adopted a more comprehensive approach, with emphasis extended to hypertension, kidney diseases, diabetes, and plumonary diseases, among others. All of these diseases affect the health of the aging and aged, thus lessening the impact of chronic long-term illness. At the same time, however, it must be noted that RMP activities also have an effect on the entire life-span of the general population, and are also dependent upon established local jurisdictional priorities.

Efforts aimed at improvement of care for the aging appear in a number of patient-care demonstration activities and training programs in areas such as disease detection and prevention (screening activities), health education (aimed at the general public as well as the individual patient), patient follow-up, rehabilitation and improved care for the ambulatory, as well as demonstrations in the care of aged and aging persons. From its inception, the Regional Medical Programs Service has adhered quite rigidly to the tenet that self-determination of priorities and needs in the local geographical entities are basic program decisions, to be left to the individual RMP.

Currently, in the 56 Regional Medical Programs there are a total of 978 ongoing programs and projects to which operational grants in the amount of $73,525,711 have been awarded. Three hundred and sixty-eight (368) projects (over 37.6% of the total number of projects) and $25,441,342 (34.6% of the total funds) are allocated to categorical disease activities, specifically to heart diseases, including hypertension, cancer, stroke, kidney diseases, diabetes, and pulmonary diseases. The disease categories enumerated are primarily diseases of the aging and aged; and, while they are not specifically focused toward the "65 years and older" age group, the activities include these diseases as an integral part of the coordinated system that provides comprehensive health care to the adult population. Twenty-four (24) of these 368 projects (6.5%) are specifically designated as targeted toward the age group 65 years and older. A year earlier, only three of 294 projects (just over 1%) were so designated.

From another point of view, 204 projects have been specifically designated as providing services under the following headings: extended and long-term care projects (33); home health care (46); inner-city poor (74); other rural poor (27); and poor, not specified (24.)

In the area of stroke, the Virginia RMP initiated a treatment and rehabilitation program in a rural community whereby seven rural physicians were given training and consultation. Approximately 300 patients received benefits from this project, which is continuing under the aegis of the Medical College of Virginia, after receiving 2 ½ years of RMP support. The medical director of the project is volunteering to provide consultation gratis, while the rural physicians are contributing funds for support.

Six hospitals in Monmouth and Ocean Counties, New Jersey, are cooperating in a comprehensive stroke care and educational project for physicians and nurses. It is aimed toward improvement of patient care. This area of New Jersey has a large percentage of the state's aging population and stroke patients. The project is purported to have improved management and treatment of stroke patients.

In approximately five years, the Presbyterian Hospital, Dallas, Texas, through support from the Texas RMP, treated over 975 patients in their stroke demonstration project, although it was originally designed solely as a teaching-service program so that physicians, nurses, and allied health personnel could be better trained to deal with the aging and aged stroke patient. As an on-going activity (no longer supported by the Texas RMP), between 15 and 20 patients are seen monthly.

For three long years, an elderly stroke patient had lain in his bed in a nursing home, unable to speak. As a result of training received through the Washington/Alaska RMP, a nurse's aide who had attended a local course in restorative patient care decided to apply some of her newly learned skills to this patient. A short time after, she had the patient up and walking, and able to perform routine daily activities. Eventually, through the nurse's efforts, he even regained his ability to speak.

In a nearby nursing home, an R.N. decided to help a wheelchair patient regain the use of his left hand, which he had not used for 19 years. Her success was added to the store of similar incidents which demonstrate the results of locally initiated training in restorative care. A number of other such accomplishments can be recounted from records of the 58 stroke projects in the 33 local regions which have stroke projects.

Washington/Alaska RMP has helped to establish two rural health clinics for the elderly who live in isolated areas and depend upon nurse-practitioners for everyday medical treatment. Two additional clinics are scheduled for establishment and attest the success of the project.

Because high blood pressure may not manifest any signs or symptoms until it strikes its victims with "heart attack," stroke, or kidney disease, a vigorous search has been undertaken by the Georgia RMP in its community hypertension program. For the past two years this program for the detection and control of this disease has been in operation.

In some regions, emphasis as a priority item has been focused on provision of ambulatory care and home-care to senior citizens. For example, a thousand older citizens of the inner-city barrio were the particular target group for health care of a project in the California RMP. The feasibility of an ambulatory, total follow-up health care clinic for the "over-50" age group was investigated. Data have been collected and solutions sought to such needs as specific health problems, special problems that influence or affect the health of the aging, transportation, and the need and utilization of different types of home care services. In Missouri, a service has been made available on doctor's referral to the chronically ill and/or aging

patient in the home. The "home-maker—health aide" project trained a corps of workers to do simple nursing procedures and "personal care" services such as preparing meals, light laundry and housekeeping, and grocery shopping. The "aides" work under the supervision and direction of an R.N. Over 950 days of nursing home care and almost 10,000 days of hospitalization have been provided during the 2½ years of the project. These services also permit releasing hospital beds for patients with more acute problems. During the last year seventeen home health aides, in a project of the Susquehanna Valley (Pennsylvania) RMP, made over 5,500 visits to patients with heart disease, diabetes, stroke, arthritis, cancer, and other chronic diseases. Of the patients visited, three out of four were over 65 years of age.

Health care for elderly patients has been given higher priority in many regions by the multiphasic screening projects for detection and treatment of hypertension, heart disease, cancer, stroke, diabetes and other chronic diseases. The North Carolina RMP funded a two-county heart association effort in which more than 100 individuals per five-hour day were screened from senior citizens clubs; ultimately nearly 40,000 persons were reached in the six-month period. HOPE, a community health center serving more than 74,000 persons in a seven-square mile area of Milwaukee's inner-city provided primary health care, demonstrated the effectiveness of the nurse practitioner, developed relationships with other health care providers, and provided for cooperation of community health workers as outreach personnel.

Many endeavors of the Regional Medical Programs have not been specifically geared to the aging and aged, because of the disease entities concerned. Definite progress has been made in providing more adequate thrusts in physical, mental, and social aspects of the elderly as an integral part of the RMPS mission. As agents of change, the local RMP's have, for the first time, brought to the conference table and into cooperative arrangements and alliances, the universities, the official and voluntary health agencies, and the providers and consumers of both majority and minority persuasions. Moreover, the Regional Medical Programs Service activity relates to other Federal programs which affect the aging, such as Model Cities Program, Office of Equal Opportunity (neighborhood health centers), Veterans Administration, and Appalachia, among others.

Concomitantly, in light of the renewed interest and concern for the aging and aged, Regional Medical Programs Service activity strives to foster and strengthen the thrust of health programs for the elderly. It actively endeavors to improve the relationships and alliances between talent and problems, between public and private sectors of the community, and between providers and consumers. There are important and integral goals of the on-going comprehensive health programs of the RMP's. The problems of the aging and aged are definitely included in the effort to fulfill the prescribed role and responsibility of the Regional Medical Programs Service, while not shirking its responsibility in the total health care system.

Health Maintenance Organization Service

The Health Maintenance Organization Service (HMOS) was established within HSMHA in 1971 to serve as the lead agency for HMO development. It was established as a part of the Health Care Strategy proposed by the President in his Health Message to the Congress. Such a program contains far-reaching importance to the elderly. The organizational format is very flexible, and the HMO brings together a comprehensive range of medical services which it provides to all subscribers for a prepaid fixed contract fee. The older person has the option of joining an HMO for Part A and Part B coverage of Medicare or continuing to receive services in the traditional—and often fragmented—manner.

The recent passage of H.R. 1 ". . . authorizes medicare to make a single combined Part A and B payment, on a capitation basis, to a 'Health Maintenance Organization,' which would agree to provide care to a group not more than one-half of whom are Medicare beneficiaries who freely choose this arrangement." This will be effective July 1973.

During the calendar year of 1972, at least 10 HMO's became operational as a result of receiving financial assistance from HSMHA. A full range of technical assistance services are available to our current HMOS grantees to facilitate development into operational HMO's.

While HMO services are intended to be available to all, and not just to the elderly, the concentration on accessability, prevention, efficiency, and cost consciousness will be of particular value to the elderly in view of their higher-than-average utilization of services.

OFFICE OF THE DEPUTY ADMINISTRATOR FOR MENTAL HEALTH

National Institute of Mental Health

During the year the Institute intensified its activities to implement its focus on Aging as a named priority. Progress was made in responding to the White House Conference recommendations, primarily in the area of planning and evaluation. Extramural research grants affecting the elderly were increased. Training activities were augmented, particularly affecting nursing home manpower. Hospital staff development and hospital improvement grants continued to benefit significant segments of the mental hospital geriatric population. Collaborative activity with other agencies, States, professional groups and citizen organizations provided a productive channel for mental health input in developing policies and procedures in furtherance of national program goals. State mental hospital populations, reflecting the impact of this and related activities, have continued to decrease. The elderly constitute the largest single age group in that population.

The Institute has engaged in a series of interrelated planning and evaluation activities directed at providing a firm data base for expanded programs for the elderly.

An Ad Hoc Inter-Divisional Work Group was convened in the early months of 1972 to review the findings and recommendations of the White House Conference on Aging, to guide in the development of comprehensive inventories of all the National Institute of Mental Health-funded service, training, and research projects related to the aging, to prepare for the development of a major evaluation of the National Institute of Mental Health aging aspects of residential care and is being widely distributed and utilized in training of nursing home personnel. A script which will be used for developing an audio-visual aid tape has been completed and will be used to supplement training for mental health personnel.

COMMUNITY MENTAL HEALTH CENTERS PROGRAM

All Community Mental Health Centers are required to provide the five essential mental health services to all ages of the population for which they are responsible. Within the 325 centers operational as of June 30, 1972, 50 centers additionally provide for special services to the aged. Data reveal that the aged are receiving services but in lower proportion to their percentage of the general population.

The Institute has become increasingly aware of the seriousness of the unmet needs of the aged and has encouraged Community Mental Health Centers to do more.

The National Institute of Mental Health has also begun to study the multiple relationships between Community Mental Health Centers, State hospitals, and other community agencies that will be necessary to alleviate mental health problems of the aged.

Annual site visits and consultation to Community Mental Health Centers for the past two years have highlighted this need and urged concentrated effort to attain a higher standard of care for the aged population in each Community Mental Health Center catchment area.

HOSPITAL IMPROVEMENT PROGRAM

The Hospital Improvement Program is directed toward improving the program, and to begin to review existing data for the purpose of developing program plans for the aging.

A mental health strategy was developed, a major planning analysis paper was completed in the autumn of 1972, a project to evaluate NIMH efforts in behalf of the mental health of the elderly was developed under contract and preliminary results related to research have been received. The final report should be available late in 1973 and will present data and conclusions related to services and training programs as well.

Data and program plans that could be implemented, should additional resources be made available, have been developed. The beginnings of a coordinated data base for the planning and evaluation of programs for the mental health of the aging are being made.

TRAINING

The major portion of the National Institute of Mental Health training funds concerned with aging is being used in support of training grants, including teaching costs and trainee stipends, fellowships and research development awards. There

is increased interest in the curricula of mental health professionals and in the training of new types of workers to care for the elderly and provide preventive mental health services. Other training efforts related to aging are ongoing in the social work and continuing education programs, as well as the various behavioral sciences, including psychology, biology, sociology, and research development and fellowships.

In 1972, 20 institutions and 66 trainee stipends were supported under the training grants program, 10 fellows in 7 institutions were supported under the fellowships program, and 6 scientists and 5 institutions were supported in the research development program.

A new program of support for training of personnel employed in nursing homes and long-term care facilities was inaugurated in the fall of 1971. This program is part of a DHEW initiative for improving services to the elderly, and represents coordination of efforts of several organizational units within the Department, including the Regional Offices. The National Institute of Mental Health is responsible for developing training activities designed to improve skills and increase knowledge of personnel in the mental health aspects of long-term care, with special concern for preparing staff to meet the special needs of former mental hospital patients being placed in nursing homes. Plans are underway for some joint project support in FY 73 to demonstrate the integration of mental health concepts into general nursing home training programs.

There are 5 demonstration training projects in 5 training sites, and one national project which is being conducted in collaboration with the Gerontological Society.

SPECIAL PROGRAMS

Staff continues to collaborate with other DHEW agencies in special programs resulting from the President's Nursing Home Program, initiated August 1971. A task force formed to assist the States in establishing Investigative-Ombudsman Units have studied criteria for implementing the Units. A related subcommittee has completed a policy paper outlining conceptual and operational framework for five demonstration projects which are now underway. Staff continues to work with the HSMHA Project Director on ombudsman issues relating to mental health.

The Institute participated in selected State program audits on the Medicaid program to evaluate the coverage and effectiveness of mental health provisions of the State plans.

Staff has collaborated with Community Health Services, Medical Services Administration and Bureau of Health Insurance in the formulation of new regulations for skilled nursing facilities (H.R. 1 requirements).

Staff has continued to participate in the development of new Intermediate Care Facility Standards under Title XIX. In addition, staff will assist the Medical Services Administration in developing regulations and guidelines for the implementation of new legislative provisions which call for periodic on-site inspections of Intermediate Care Facilities and increased Federal authority to institute life safety codes in Intermediate Care Facilities.

Staff continues to participate in the training programs for State surveyor personnel, in addition to participation in workshops with Community Health Services, Bureau of Health Insurance, Medical Services Administration and training faculty from three surveyor basic training programs to study, evaluate, and suggest changes in total program. A manual prepared for use in mental health programs for State surveyor personnel which was developed with Tulane University School of Public Health has been completed, published, and is currently being used ("Psychiatric Services in Health Care Facilities," 1972).

A document, "It Can't Be Home," prepared by Institute consultants, became available in January 1972. It describes the social and emotional treatment, care, and rehabilitation of the mentally ill in 302 eligible State-supported mental hospitals throughout the nation. It is specifically focused on the use of current knowledge in demonstrating improved services for patients, stimulation of the process of change and the development of relationships with community mental health programs. Funds are available through the grant mechanism for support of programs that are designed to explore and validate new methods of treatment, and to develop new knowledge.

During fiscal year 1972, seven projects were concerned with aged persons. Although each project used different methods to achieve its objectives, many noteworthy results were reported. Some of these were: minimizing the dependence on the hospital, the acquisition or relearning of social skills, restoration of physical

functioning, higher rate of discharge, and remotivation in terms of individual skills and interests.

HOSPITAL STAFF DEVELOPMENT

The Hospital Staff Development grant program is designed to stimulate and assist State mental hospitals in initiating a sequence of change and improvements throughout the institution. It was also intended to help State hospitals achieve a more positive role as an integral part of community programs and to help the communities benefit from the unique contributions the institutions can make to comprehensive community programs.

The original goal was to strengthen and expand the training to provide opportunities for all levels of personnel to increase skills and knowledge in order to be more effective in meeting the needs of the patients by introducing active treatment methodologies. The service to patients has also been improved by changing the attitude and expectations of both hospital staff and the community in directions consistent with new knowledge about treatment and the social changes occurring in the country.

During the fiscal year 1972, 152 State hospitals were awarded grants. There are no records available on the number of aged served by staff who received training supported by Hospital Staff Development funds, as they are awarded to a hospital for total Staff Development. Records for 1970 indicate that there were 337,619 patients in State hospitals; of these 99,087 or approximately 33 percent were over 65. It is estimated that a good majority of these were benefited by this training.

PUBLICATIONS

Two major publications were issued on aging by the National Institute of Mental Health that are enjoying wide acceptance. They are: *Human Aging II: An Eleven-Year Followup Biomedical and Behavior Study.* This publication comprises the findings from an 11-year followup of the original human aging study performed at the National Institute of Mental Health.

The Aged and Community Mental Health: A Guide to Program Development, was produced in collaboration with the Committee on Aging of the Group for the Advancement of Psychiatry. This publication is intended to stimulate and provide program development guides for work with the aging on the part of Community Mental Health Centers.

A third publication, *NIMH Research on the Mental Health of the Aging,* was also completed and contains summaries of the research in mental health of the aging supported by the National Institute of Mental Health during the past 12 years.

In process are publications on:

(1) A Social Work Guide for Long-Term Care Facilities;

(2) A Training Manual on Care of the Mentally Impaired and Aged Individual; and

(3) Retirement: Patterns and Predictions.

Final revisions were made on the paper Patterns of Use of Psychiatric Facilities by the Aged: Past, Present and Future for publication by the American Psychological Association in their book Task Force Report on Aging. Publication date is set for early 1973. A shortened version of the paper with updated statistical data and other revisions in language and content aimed primarily at an audience of general physicians was prepared for publication by the American Psychiatric Association in their book Mental Illness in Late Life. The title of this revised paper is Epidemiology of Mental Illness and Utilization of Psychiatric Facilities Among Older Persons.

A Workshop to explore the use of volunteers dealing with the mental health needs of the elderly was held during the year. Participating were volunteers, volunteer coordinators, older persons and youth. A booklet, based on this meeting, is in the process of preparation. It is intended for use by Community Mental Health Centers, volunteers and programs both serving older persons and using them as volunteers.

STATE PROGRAM DEVELOPMENT

In an effort to better respond to the mental health needs of the States, the Institute has inaugurated a process of State program development. Intensive activity has begun in two States, Ohio and Maine, both of which have specified aging as an area where resources need to be better synchronized.

The Director of the Ohio Department of Mental Hygiene and Mental Retardation established a Departmental Work Group for the purpose of: (1) studying

the available approaches open to the Department in developing a comprehensive service delivery program for the aged in the State of Ohio and (2) defining services, programs, staffing, and facility patterns for five proposed geriatric centers, each center to have a patient population of approximately 150 patients and located at the following sites:

Toledo Mental Health Center; Athens Mental Health Center; Dayton Mental Health Center; Hawthorndon State Hospital; and Massilon State Hospital.

As part of the State Program Development effort in Ohio, technical assistance and consultation was provided to the Work Group by Institute program specialists functioning as part of the State Program Development Team.

One of the State Program Development objectives for Maine is "Development of a State plan for coordinated services for the aged and implementation in at least one demonstration area." This objective was formulated as a result of the assessment of Maine's mental health system because it was found that the State hospital population was 40.8 percent geriatric, largely due to lack of alternatives to State hospitalization.

The State Program Development staff has met with the Director of the State Division of Services to the Aged to explore ways of collaborating in the develop- of plans and programs for mental health services to the aged on two levels: (1) planning for mentally ill aged; and (2) planning for the mental health of the aged.

The State will request the National Institute of Mental Health-State Program Development staff: (1) to meet with the State Committee on Aging to discuss appropriate approaches to planning for the aged; and (2) to assist the Bureau of Mental Health and the Division of Services for the Aged to develop specific goals and objectives for providing services.

A State-wide network of senior citizens and councils already provides both planning and evaluation of services but has not yet addressed the mental health needs of the elderly. These groups will be involved in the State Program Development efforts to achieve the objectives.

National Institute on Alcohol Abuse and Alcoholism

A variety of the National Institute on Alcohol Abuse and Alcoholism programs have some bearing on meeting needs of the aged. The Occupational Alcoholism Program working with employees in the private sector through early identification techniques and rehabilitation, gives leadership to program development that helps insure employability and productivity of people as well as the opportunity to enjoy increased longevity brought about by advances in social health technology. This illness allowed to go unchecked not only reduces life expectancy by ten years but renders people helpless. Other programs of the Institute such as those dealing with manpower development, treatment and rehabilitation techniques and services delivery systems, and prevention of alcohol abuse and alcoholism focus on helping people to help themsevles whatever the age. These new activities have opportunity to begin meeting the specific and special needs of the elderly.

The National Institute on Alcohol Abuse and Alcoholism is also contemplating conducting a study of drinking practices and alcohol effects in people 70 years and older since there has been no systematic study of the value of alcohol for this special population. Empahsis is expected to be on normal use and possible therapeutic effects of alcohol in people of this age group.

ITEM 15. OFFICE OF NURSING HOME AFFAIRS

April 16, 1973.

Dear Mr. Chairman: Thank you for your letter of March 30 inviting the Office of Nursing Home Affairs to contribute to your report, *Developments in Aging.*

The Report serves a very useful purpose in that it gathers together a great deal of information about programs and concerns for the elderly. Enclosed is an update on the progress made in the President's initiatives, and this office's role in the nursing home improvement effort. We are hoping for even more significant progress in the coming year.

Sincerely yours,

Marie Callender,
Special Assistant for Nursing Home Affairs.

[Enclosure]

THE OFFICE OF NURSING HOME AFFAIRS

The Office of Nursing Home Affairs was established in November of 1971 in response to the President's call for a coordinated response to the problems of substandard nursing homes and greater efforts to improve the situation of patients in these homes. The President directed the Secretary of Health, Education, and Welfare to take charge of the increased activity in this area. The Office of Nursing Home Affairs has the responsibility, delegated from the President to the Secretary and the Assistant Secretary for Health, for overseeing and coordinating all programs and efforts related to long term care and the improvement of standards enforcement within the Department.

In these efforts we have worked closely with the Regional Offices as well as the agencies of HEW to guide these efforts, to increase the Regional Offices' capabilities to deal with problems on a regional basis. The Regional Offices have also provided invaluable assistance to this office in the implementation of the extremely important provisions around long term care contained in the Social Security Act Amendments of 1972.

The Office of Nursing Home Affairs in the past year has directed its efforts toward a variety of fronts in order to improve the quality of care provided to nursing home patients, most of whom are aged.

1. Enforcement of Standards

The first major aspect of these efforts involve increased surveillance and enforcement of the nursing home standards already on the books. In response to President Nixon's expressed desire to cease payments to nursing homes not meeting these Federal standards, the Department established a deadline of February 1, 1972, for the States to have in place the proper survey and certification procedures. A deadline of July 1, 1972, was established for the proper inspection and certification of all skilled nursing facilities participating in the Medicaid and Medicare programs. A major result of the activities around the February 1 deadline was a significant increase in the States' capabilities to perform their function of inspection, certification and technical assistance to facilities. These mechanisms were actually put into practice when they surveyed some 7,000 skillled nursing homes to meet July 1, 1972 deadline.

As of that date, 6,479 nursing homes were given new provider agreements, and 579 facilities were decertified or withdrew from the Medicaid program. Our widespread certification effort did not end there; for example, during the period October 1 to December 31, 1972, a total of 2,467 facilities were surveyed and certified. This has meant a significant continuation of the efforts on the part of State personnel to maintain a rigorous schedule of survey and certification. Of special interest is the fact that the number of homes certified for a twelve month period as of December 31, 1972, amounted to 2,336 or 34 percent of a total of 6,839 homes certified. On July 17, 1972, only 24 percent or 1,469 of the total of 6,479 certified homes had 12 month provider agreements; all the rest had 6 month agreements which meant that they had correctable deficiencies. These data are significant in that they indicate that nursing homes are taking significant strides toward eliminating deficiencies. Currently under Title XIX (Medicaid), 6 month agreements are given to homes with correctable deficiencies and 12 month agreements are given to those with no significant deficiencies. It is apparent that the increased joint Federal/State activity in improving the certification and survey process and in assisting nursing homes by providing technical assistance to correct deficiencies had led to the good progress in this area.

The Regional Offices have grown through our experiences with these certifications. Since the nursing home improvement program was in a large part their responsibility, the various regional agencies learned to share and cooperate in order to fulfill their role in the decentralization of some of these activities from the Central Office. They are now prepared, with the help of increased staff and expertise, to accept more and more responsibility for program development and implementation in the area of long term care. This includes the regional capability to monitor grants and training programs, the development and implementation of new standards and increased ability for policy formulation. Progress has been made, both in the Regional and Central Offices, in achieving much better administration, coordination, and quality controls in long term care programs for the elderly. We now feel that we are in a good position to assure that Federal funds no longer support substandard care in substandard facilities.

Other specific ways in which the Department has helped to improve State capabilities to perform surveys and certifications include our request (passed in the 1972 Social Security Act Amendments) 100 percent Federal reimbursement to States for the costs of performing these inspections. In addition, we have expanded our surveyor training so that month-long programs are offered in four universities around the country: all surveyors in State agencies who wish to do so will have received training in these programs by July 1, 1973. These courses are designed to provide orientation to Federal standards, methods of surveying a nursing home, how to take into account patient care and the general atmosphere of the home, life safety code surveys, and how to provide consultation to the nursing homes needing assistance in correcting deficiencies.

2. Life Safety Code

An additional extremely important step toward insuring the health and safety of patients in nursing homes is the fact that in January 1971 the Life Safety Code was adopted by both the Medicare and Medicaid programs. The Life Safety Code, a publication of the National Fire Protection Association, sets forth requirements for construction, equipment, and occupancy of health care facilities which are intended to minimize danger to life from fire, smoke, fumes and panic. The new regulations, issued in October, 1971 pursuant to the requirements of the Social Security Act, provide that skilled nursing facilities participating in Medicare must also meet the applicable requirements of the code. Efforts to survey all Medicare and Medicaid skilled nursing facilities for the Life Safety Code are well under way. Medicare and Medicaid have coordinated with one another so that a single State authority will be responsible for conducting fire safety surveys for both programs, and have put into use a joint survey form. Regional training sessions have been held for State fire safety surveyors.

Regulations issued by the Department of Health, Education, and Welfare provide that specific requirements of the Life Safety Code may be waived if the approving authority (the single State agency in Title XIX and the Social Security Administration in Title XVIII) determines that strict enforcement of such requirements would result in unreasonable hardship to the facility and that the waiver of such requirements will not adversely affect the health and safety of the patient. Determinations for granting waivers must be supported by full documentation. A joint policy statement issued by HEW sets forth the policy with respect to granting waivers on two Life Safety Code requirements: automatic sprinklers, and type of construction.

With respect to the automatic sprinkler requirement the policy statement sets forth conditions that a facility must meet in lieu of installing sprinklers, which afford protection to life *equivalent* to that afforded by a sprinkler system. The waiver of this requirement and equivalent conditions apply only to one story one hour protected wood frame facilities, and does not apply to multi-story facilities nor to one story unprotected wood frame buildings.

3. New Standards for Long Term Care Facilities

An important new tool in our hands is the ability for the first time to make Intermediate Care Facilities subject to Federal regulation. Published as Proposed Rule Making on March 5, the new regulations will govern over 6,000 facilities, and will add a new level of health related care for the many who need it under the Medicaid program.

Intermediate Care Facilities are intended to provide care to persons whose health status requires services beyond what is available in the home, but less intensive than those of skilled nursing facilities. An ICF patient, because of his physical and mental condition, requires living conditions and care which as a practical matter can be made available to him only in institutional settings. The ICF will make available an additional level of care to an enlarged eligible population which now includes the medically indigent.

Unlike skilled nursing facilities, which are more or less similar in character because the group they serve is more limited by definition, the term Intermediate Care Facility includes a broad range of care. In addition to specialized ICF's for the mentally retarded, the ICF will include a range of facilities from those which provide nursing care just slightly less than that of skilled nursing to institutions serving residents who need minimal medical and nursing service but who do need health supervision in conjunction with a variety of other support services. A broad

range of rehabilitation, recreation, and social activities will be available to those patients to maintain or increase their ability to remain as independent as possible and to curtail further physical and mental disability. Additional major areas covered by the regulations are health care supervised by a full time licensed nurse (either a registered or a licensed practical nurse), and periodic evaluation by a physician. Further, ICF's must arrange for hospital, skilled nursing, and other medical services for their patients as needed. ICF's would be required to meet the standards of the National Fire Protection Association's Life Safety Code, have active treatment plans, medical audit, and utilization review. After a phase-in period of two years, the ICF would no longer be required to maintain separate and distinct sections for ICF's and skilled nursing care if it provides both.

The proposed regulations authorized ICF care for Medicaid patients in institutions for the mentally retarded and in institutions for victims of cerebral palsy, epilepsy, or other neurological conditions defined under the Developmental Disabilities Act. These institutions must provide health and rehabilitative services. The importance of noninstitutional alternatives to this institutional care is stressed in the regulations. Thus, a State Medicaid agency would evaluate an individual's need for institutional care before Medicaid payments were authorized, and the State agency would periodically review the quality of care provided by the institution together with the individual's continued need for institutional care.

In summary, the proposed regulations provide a further, more appropriate option for health care to the elderly. Skilled nursing facilities and custodial care homes or institutions should no longer be used inappropriately. They should contribute to a better continuum of care for the elderly at less cost.

The Social Security Act Amendments of 1972 mandated that Medicare and Medicaid must have common standards for skilled nursing facilities by July 1, 1973. The Office of Nursing Home Affairs has had the lead responsibility in developing and drafting these standards. A special Ad Hoc Task Force has been working for several months on these new regulations, which will consolidate the present extended care facility and skilled nursing home regulations into a single coherent body, meaning that the State survey agency will only need to perform one survey, and the facility will only have to fill out one set of forms. It will also provide a common and more easily understandable definition of care, eligibility and services. These regulations will be published as Notice of Proposed Rule Making prior to July 1.

4. Assistance to Nursing Homes

HEW has initiated efforts to provide assistance to long term care facilities through training of employees in these facilities. Short term training programs will be provided for about 40,000 nursing home employees by the end of June 1974. The training programs will be geared to ensure better performance and capabilities on the part of employees in giving necessary care to patients in nursing homes. Prototype training programs have been developed by the Community Health Service and the National Institute of Mental Health in conjunction with this office and with several national organizations representing the professional groups to be involved in the training. While the goal is to train these 40,000 nursing home employees, we are hoping to be able to reach the approximately 500,000 employees working in nursing homes by making these training projects prototypes for wide use. In other words, they would be demonstrations and development of curriculums which could be translated and used in other ways and by States and nursing homes as they are able to do so. Thus, these contracts are for curriculum development and testing as well as to provide a significant amount of actual training. Contracts with the American Nursing Home Association to provide training to 10,000 patient activities directors, and with the American Nurses Association to provide training in geriatric nursing for 3,000 registered nurses now employed in nursing homes are well underway. Also in progress are contracts with the American Medical Association to operate 10 prototype seminars for medical directors and nursing homes and the Association of University Programs for Hospital Administrators to provide orientation for nursing home administrators.

Funds are being provided for contracts with more than 10 State agencies and organizations to provide training to nurses' aides and other crucial nonprofessional employees of nursing homes as well as professional staffs. Some States are utilizing the team approach to training; for example, the Colorado Associated Nursing Homes assembled a team of five specialists to provide specialized group and

individual training to improve personnel and services. South Carolina is emphasizing training in the areas of psychological, social, and rehabilitative needs of the elderly, and Iowa provides assistance in remotivation, rehabilitation, and nutrition of the elderly. These training programs are enabling States to evaluate training needs and develop training programs on an on-site basis. Approaches to mental health problems of patients in nursing homes will be developed by the National Institute of Mental Health and the Health Services and Mental Health Administration's staffs working with the American Gerontological Society. Projects developing innovative teaching methods are also being developed.

5. Research and Development Studies in Long-Term Care

The Office of Nursing Home Affairs is responsible for a comprehensive review of long term care and related areas ordered by the President. The office, in conjunction with other groups within as well as outside the Department, has identified primary issues of long term care needing additional study, with emphasis on the quality of care, alternatives to institutional care, data collection and analysis, and the costs of long term care. A number of projects related to these areas are presently being funded. One anticipated result of these studies will be a comprehensive Federal policy for programs relating to long term care and the elderly. The results of various cost studies will be analyzed and evaluated and from them the Office of Nursing Home Affairs will develop proposals designed to help alleviate some of the cost problems involved in nursing home care.

The ultimate goal of our entire efforts to improve nursing homes is the improvement of the quality of life of citizens using long term care facilities either as a short term transitional resource or as a long term residence. This initiative is based on a widely held belief that the quality of life for many of our older citizens in these facilities is far from adequate. Quality of life for the elderly in such institutions includes the prevention of avoidable decline and complicating morbidity, the maintenance of physical and social function, and the restoration of or compensation for lost or diminished function for individual patients and thus for the aggregate. In this definition of quality of care, several areas lend themselves to measurement.

One consideration is the quality of the institutional environment. The "living environment" which fosters quality will meet social and psychological needs of patients in addition to providing medical care. It also includes nutritional adequacy and freedom from physical hazards, unsanitary conditions, and procedures for handling drugs. The second area is an accurate assessment of the patient's emotional and physical status, and his potential for maintenance or improvement. Third, there is a consideration of finding a reliable method of matching each patient's needs with an appropriate environment in a facility, i.e., which patient belongs in a skilled nursing facility, which in an intermediate care facility, and so forth.

Some of the projects we have funded to study quality of care are the following: 1) Rush-Presbyterian-St. Lukes Medical Center, Chicago, Illinois: "Objective Scales for Measurement of Quality Care and Life in Nursing Homes and Other Long Term Care Facilities." This project will assemble and pilot-test objective scales of patient needs, institutional environment, and patient placement in the long term care facility in order to assess their validity and reliability. 2) Health Services Research Center, Harvard Medical School: "An Approach to the Assessment of Long Term Care." This contract will determine if a system of patient classification currently being developed can be used as a tool for developing care plans based on goals for each patient so that their medical, social and psychological needs are met as effectively as possible.

The need for coordinated data collection and analysis is obvious. Thus, we have attempted within the Department to gather all of the existing resources and facilities for data collection and analysis into a centrally coordinated system for all of HEW's agencies.

Improving the Master Facilities Inventory (MFI) of the National Center for Health Statistics is a good way of obtaining additional data through a biennial census of all nursing homes which is to occur this Spring. The facilities inventory is being expanded into a comprehensive nursing home data collection system which will provide a method of producing data for Medicaid and Medicare participant homes, and strengthen the current data collection systems to provide indicators that can be used in evaluating quality of care. It is hoped that from the latest MFI, we will be able to interrelate these cost, facility, and patient data

to reveal the relationships that exist between costs and such variables as staffing, services offered, and the physical condition of patients. The MFI survey will provide basic facility characteristic data and will serve as the universe from which the survey sample will be drawn for this data collection system.

In addition we are establishing, at least on an experimental basis, an interrelated system between HEW and State and local agencies. Present efforts within States and communities are being evaluated, expanded, and connected. The long range goal of this system would be to provide a nationwide network which could provide selected data for national use, selected data to individual States and communities, and be available for specific surveys and sample data collection. Thus, in addition to a number of projects in Federal/State/Local data linkage systems, we are funding two specific long term care projects to derive data about nursing homes. One is a contract with the Iowa Hospital Association, "Long Term Care Component-Iowa Health Data System." This project will develop a uniform data system for long term care patients and institutions that will permit effective planning, management, and licensing of long term care services, and 2) determine the feasibility of implementing collection of long term care data on a Statewide basis in Iowa. The study is expected to produce a variety of useful recommendations and information. We also have a contract with the Department of Public Health in Illinois, "An Evaluation of the State of Illinois Automated Systems for Long Term Care." This project will evaluate the automated system for regulation of long term care facilities and medical review of patients that is now operating in the State of Illinois. This study is expected to produce a great deal of information on compatibility of this with other computer systems, measurement and retrieval of information on provider performance, quality of operations, and problems in deriving data on major elements of each facility. Once the automated system is tested and proved to be effective it is hoped that it will be recommended to other States.

6. Development and Study of Alternatives

Since the enactment of Medicare and Medicaid, heavy emphasis has been placed upon providing institutional care. With few or no alternatives available, many elderly people have found their way into institutions who might have been able to avoid them with a little help.

Demonstrations over the years of the feasibility of home health services, day care, rehabilitative services, and home care services, has shown that these services do provide people with support needed to remain at home. A resurgence of interest in alternatives has led to the establishment of a new sense of priority within HEW.

We realize that, while we are sure alternatives to institutional care can provide the answer for many people, we still do not know the "how many" or "whom," these services can benefit. Therefore, we have funded a number of projects in home health, day care, and rehabilitative services to tell us not only that they are feasible, but how much they cost, how many and what kinds of people they can help, and the most appropriate ways of delivering these services.

In addition to these demonstration projects, we are beginning to gather hard information through studies of populations at risk for institutionalization—how many, who, and why. We can then begin to estimate numbers, types, and costs of needed community services. We are also studying how best to reduce or eliminate barriers to the use of such services. For example, home health care is currently being provided as an alternative to skilled nursing care under Medicare and Medicaid; we are exploring the possibility of broadening opportunities for Medicaid patients to utilize home health services as an alternative to the Intermediate Care Facility.

Some of the projects we have sponsored in the day care arena include day hospitals to provide rehabilitative, preventive, and other health services to chronically ill and disabled adults. Others include day care in nursing and Intermediate Care Facilities and in elderly housing, to meet medical, social, and recreational, and nutritional needs of the elderly.

7. Increasing Patient Involvement

In order that patients, relatives, and friends might have a voice in the quality of care offered in nursing homes, a central focus of complaint and patient concerns has been established in the Social Security Administration's several hundred District Offices throughout the country. Thousands of complaints have been received over the past year and a half and have been generally concerned with

the quality of nursing care, quality and amount of food, unsanitary conditions, theft, patient abuse, and fire and safety hazards. All complaints are referred to the State inspection agencies to be investigated and dealt with as necessary. This, however, is only an interim measure.

HEW has developed several model investigative-ombudsmen programs to be tested and implemented, with the object of finding ways to provide a permanent voice for patients in nursing homes. These ombudsmen will represent patients to local, State, and Federal government agencies as well as to providers in order to see that their rights are adhered to and to see that their comfort and dignity are maintained. The demonstration programs include a variety of models in Governors' offices, State aging agencies, and national and local voluntary organizations. It is hoped that of these demonstrations will yield enough results to help other States decide what would be the most workable kind of patient spokesman. The projects are in Idaho, Pennsylvania, South Carolina, Wisconsin, and the National Council of Senior Citizens with Michigan as the demonstration area. Excellent progress has been made by all of these projects so far, and their evaluations should provide much useful information.

ITEM 16. POST OFFICE DEPARTMENT

MARCH 9, 1973.

DEAR MR. CHAIRMAN: This is in response to your request of December 15, 1972, we are pleased to furnish, for your consideration in preparing your report "Developments in Aging—1972," the following information relating to this agency's activities that may be of special interest and of informational value to our elderly consumers.

The United States Postal Service was created by Congress to unite, more closely, the American people; to promote the general welfare and to advance the national economy. Throughout the years, Congress, through passage of appropriate laws, has endeavored to protect the public from criminal assault and abuse carried on through the use of the mail system. The Postal Inspection Service is responsible for the investigative enforcement of the Mail Fraud Statute, Section 1341, Title 18, United States Code. This oldest consumer protection law was enacted by the Congress in 1872, and provides that those using or causing the mails to be used to further a scheme to defraud shall be fined not more than $1,000 or imprisoned not more than five years, or both.

Working with the Postal Service Law Department, the Inspection Service also utilizes two administrative and civil actions, Section 3005 and 3007, Title 39, United States Code. The first enables the Postal Service to cause a return to senders of mail addressed to any person who is engaged in a scheme to obtain money or property through the mails by means of false representation. The second authorizes any district judge to issue, upon showing of probable cause by the Postal Service, an order to detain mail addressed to the defendant, pending conclusion of statutory proceedings.

Close liaison is maintained with the Criminal Division, Department of Justice, and the U.S. Attorneys throughout the nation. The success of this alliance is evidenced by the fact that convictions for mail fraud in Fiscal Year 1972 totaled 1,350. Numerous other fraudulent schemes were terminated through administrative action after reference to the General Counsel. This is the fifth successive year in which new records were set. During Fiscal Year 1972, 125,048 mail fraud complaints were processed, 1,965 arrests were made, and a total of 5,177 questionable promotions were caused to be discontinued. Financial recoveries by fines and restitutions amounted to $11,531,058.

The principal ingredient of a fraud scheme is deception, and crafty operators often perfect involved schemes that entice many consumers to relinquish large sums of money. It is not surprising that elderly consumers are also taken in, and that there have been schemes specifically designed for their appeal to this class of persons. In the broad sense, all consumers, regardless of age, are adversely affected when the practice of fraud is successful. The full impact of fraud in terms of economics, physical and mental suffering, the growth of cynicism, and general erosion of moral standards that accompany unimpeded violations of this nature, is statistically immeasurable.

Society's demand for protection from fraudulent practices has intensified, as commerce and business have steadily expanded with new products, services, and investment opportunities, which, in turn have provided increased opportunity

for criminal abuse. While the variety of mail fraud promotions is virtually limitless, and persons in all walks of life are potential victims, experience has shown that certain schemes have particular appeal to elderly consumers, many of whom have been victimized by these promotions. It is believed that a brief résumé of some of those schemes, as outlined herein, as well as related statistics, will be of interest to the Committee.

Medical Frauds.—By their nature, medical frauds probably affect the elderly more than any other segment of our population. Today, despite up-to-date medical facilities and warnings published in every media in almost every community, elderly people fall prey to medical quacks who depict, by means of cleverly designed advertisements, cures for a long list of geriatric problems, including arthritis, cancer, obesity, impotency, headaches, etc. Rapidly rising medical costs and lack of proper insurance coverage, among other things, influence the elderly to try these quick cures at what, on the surface, appear to be much lower in cost. The huckster's spiel that his nostrums reduce cost of medical care is difficult to believe, in view of the fact that in this field the known public loss for Fiscal Year 1972 was over $11,000,000.

In addition to prosecution, many schemes are thwarted by a timely compromise agreement being obtained between the U.S. Postal Service and the offender, thereby stopping the promotion. Such was the case recently with a company whose mail order sale of a dietary regimen claimed to cure arthritis. A medical expert advised this Service that there are many causes and forms of arthritis, and that no single treatment can be prescribed for all. Furthermore, the remedy this particular company prescribed would not effectively treat or cure any of them.

Some medical fraud schemes are not only wholly false and misleading, but can also be considered dangerous. One company in particular claimed to have developed a plan that if followed would cure the flu overnight, was a means of preventing oral cancer, would assist in extending the average age to 100, prevent many maiming diseases, and still cost less than $25. Much of the information contained in the plan could cause additional problems rather than relief, and would certainly delay the user from seeking competent medical advice, thereby increasing the hazards of the ailment. Prompt Inspection Service action put this company out of business. Investigations brought about the discontinuance of 205 questionable promotions in the medical fraud category in Fiscal Year 1972.

Solicitation of Funds.—Thousands of organizations solicit funds from the public. Appeals for contributions extend to many causes and include an endless variety of charities and betterment organizations. A heartrending appeal for a seemingly worthy cause many times finds help in the form of an elderly consumer. Unfortunately, funds solicited by unprincipled promoters often funnel into the hands of swindlers. Schemes of this type vary, but all have one thing in common—they prey on the sympathy and the desire of many to help the unfortunate.

There are numerous solicitation cases involving many types of schemes that have been in operation for years, fraudulently soliciting contributions and obtaining large amounts of money from the unwary public. Successful investigations of these cases receive much publicity, mainly because of the large amount of public loss. The offenders are finally caught, prosecuted, and hopefully receive their just reward. Little attention is given those investigations which result in early detection of a fraudulent scheme and quick action to put the operator out of business before any large amounts of money are obtained from the public. Many of these operations have the potential to become a large-scale business if they are allowed to continue. There were 257 cases issued for investigation by the Postal Inspection Service in the area of solicitations in general during Fiscal Year 1972, and of this number, 228 promotions were discontinued. Had they flourished, the potential loss is overwhelming.

Work-at-Home Schemes.—Louis Stein, doing business as Products Unlimited, advertised in over 500 newspapers, offering $2 per hour in advance for coding circulars at home. Inquiries were received from invalids, widows, students, and housewives, requesting more information. Respondents were mailed an information form letter, an application slip, and a pre-addressed envelope. The information form letter made certain representations concerning the company and the work that would be provided. It also requested the applicant to send $1, allegedly to better his chances of receiving work. Response to the request for $1 was enthusiastic. More than 150,000 persons sent their dollar. Stein did not have the means to furnish this employment, thus the unsuspecting victims were the losers. Mr. Stein was convicted, fined, and placed on probation.

This type of scheme is particularly vicious, in that it preys on those persons generally of low income attempting to supplement their meager income by working in the home. Such schemes involve an infinite variety of products and/or services to be manufactured, sold, or performed in the home. Large profits are claimed for a small monetary investment, but few, if any, are actually realized except by the swindler whose only interest is in selling the service or materials.

During the past year 239 work-at-home schemes were investigated; of this number, 208 were forced to discontinue their operation. The public loss in these cases amounted to $439,158. An estimated savings to the public, because of the discontinuance of these fraudulent operations, is estimated to be well over $482,000.

Home Improvement.—This type of fraud generally enmeshes the uninformed owners or buyers of modestly-priced homes who can be convinced that their property is badly in need of expensive repairs; or in the promotion of such items as aluminum siding, porches, patios and garages, etc. The elderly are particularly vulnerable to such threats.

In the past year, 12 investigations resulted in 8 discontinued operations. Two offenders were convicted and an estimated public savings of $101,800 was realized. Even though in most instances the scheme came to light early enough for prompt investigation to be initiated, the public suffered losses in the amount of $32,305.

A typical operation currently under investigation has resulted in the indictment of 10 persons. This scheme was conceived to defraud mostly elderly victims and a well-known loan company of funds, by obtaining home improvement loans on the basis of forged and/or inflated loan documents. A loss of at least $105,000 has been sustained by the loan company, with the loss to the private citizens even larger.

The operators used high-pressure sales tactics and misrepresentation to elderly home owners who would usually pay cash and also sign contracts. The contracts were then used to obtain the fraudulent home improvement loans in the names of the victims.

Chain Referral Schemes.—These schemes are aimed directly at low-income consumers and the elderly are particularly susceptible. Fast talking salesmen pass off desirable, but grossly overpriced appliances and home improvement items under the misrepresentation that the product will actually cost nothing if the victim will supply names of friends and associates as potential purchasers and thereby earn commission. Not until they have signed conditional sales contracts and other documents, do they realize they have actually obligated themselves to pay for a product which they often neither want nor can afford.

During Fiscal Year 1972, 39 such investigations caused the termination of 26 chain-referral schemes. Public loss in these cases amounted to $204,336, while an estimated public saving of $346,000 resulted.

Recently under investigation was such a scheme, using a sales referral plan in the sale of a well-known line of vacuum cleaners. Victims were told that the manufacturer had established an advertising fund to be used to place vacuum cleaners in homes at no cost. The only requirement being that participants were to provide names and addresses of 12 persons within one year. Even though a chattel mortgage was executed, incident to the presentation, participants were not concerned, since they were assured payments were guaranteed by the manufacturer and no repossession would be made for any reason.

The mortgages were sold to a finance company who, after discontinuance of the program, either repossessed the vacuum cleaners or made a financial settlement with each of the participants, resulting in a loss to the firm of approximately $63,000.

The exact number of participants is unknown, but from information available to date, there were approximately 300 with a total personal loss of $17,700. The two responsible parties have been found guilty and pre-sentence investigation is under way.

Business Opportunities.—Four separate, but closely-related promotions fall within this category of cases—distributorship, franchises, vending machine, and other job opportunity frauds—which lure investors with promises of high returns and guarantees of success which later prove, for the most part, worthless. These rackets frequently victimize older people who hope to profitably put to use their dwindling resources.

Investigations were completed in 203 cases causing discontinuance of 120 questionable operations. A public loss of $4,114,846 was somewhat cushioned by the fact that 32 convictions were obtained and an estimated public savings of $800,846 was effected.

Vending machine routes are particularly attractive to older retired persons, in that supplementing their income in this manner supposedly only requires part-time work. A recent case involving this type promotion in the Western United States involved four offenders. The promoters advertised for persons interested in self-employment and sold purchase agreements covering vending equipment for the sale of candy, snacks, sporting goods, and men's cosmetics. They falsely represented, among other things, that the true nature of their business was in the resale of supplies to their established distributors, rather than the sale of vending equipment, and that the vending equipment was being offered at a special price. The operators stated they would assist purchasers to assure their success, and that the purchasers should expect to earn up to $800 per month as had other distributors. Many failed to receive equipment and supplies and those who did, earned very little. The flimsy machines, and the poor on-site locations obtained on recommendation of the promotors, contributed to failure of the franchisee's venture. The total number of sales is unknown. An estimate of the three-year public loss is in excess of $6,500,000. The promotors have been prosecuted for violation of the Mail Fraud Statute.

Public Education and Fraud Preventive Program.—In order to increase awareness of the consumer, public-wide distribution is made of the Mail Fraud Pamphlet, a copy of which is furnished with this summary.* In addition, close liaison is maintained and mutually helpful information is exchanged with other Federal, State, and local agencies having a concern for consumer protection.

Along with the above-mentioned programs, Postal Inspectors made over 1,000 speaking appearances before various law enforcement, civic, educational, and consumer groups this past year. Although, in most cases, our investigations are "after the fact situations," our programs are also directed at prevention, and we are continually seeking new ways of developing greater public awareness of fraud danger signals.

I hope this summary will be helpful to you and your Committee. If we can be of any further assistance, please do not hesitate to advise.

With kind regards.

Sincerely,

JOHN W. POWELL,
Congressional Liaison Officer.

ITEM 17. PUBLIC HEALTH SERVICE

FEBRUARY 7, 1973.

DEAR MR. CHAIRMAN: We are pleased to respond to your request for a report on the biomedical research activities in the field of adult development and aging which have been conducted by the National Institute of Child Health and Human Development during 1973.

I hope this report meets your needs.

Sincerely yours,

GERALD D. LAVECK, M.D.
Director, National Institute of Child Health and Human Development.

[Enclosure]

RESEARCH IN AGING

INTRODUCTION

The average life expectancy in the United States has increased from 49 to 70 years in this century, largely due to the prevention of death from infectious diseases in the first year of life. Since 1900 the number of persons reaching the age of 65 has risen from three to about 20 million. This is a jump of from four percent to ten percent of the entire population.

The National Institute of Child Health and Human Development (NICHD) is committed to studying biological, psychological, and social processes over the total life span, and is concerned with the development of knowledge that will prevent or reduce the adverse effects of aging. Creation of a central body of sociological fact and theory to view the problems of the aging and the elderly comprehensively, and development of appropriate solutions of these problems are also of concern to the Institute.

*Retained in committee file.

The effects of aging may be said to fall into two categories—weakening of the body's defense against disease and reduction in the comfort of the elderly and in their enjoyment of life.

In the past several decades great progress has been made in detecting and measuring the loss of physiological and psychological function that occurs as humans age. Reduction in the performance of the body's organ systems has been well documented. For example, much is known about the changes that occur in the excretion by the kidney of end products of metabolism and maintenance of proper concentration and quantity of many substances within the body. Much is also known about the changes in mental abilities with age. However, until recent years little has been known about the causes of loss of function with age. Recent advances in scientific knowledge and techniques now make it possible to address many of the key questions about aging. Some of these concern the role of immunity in aging, cellular programming, the effect of age on cellular responsiveness and control mechanisms, aging in women, and the effects of nutrition and environment on aging in humans and animals.

Intramural Aging Research—The Gerontology Research Center

The Gerontology Research Center (GRC) of the National Institute of Child Health and Human Development in Baltimore, Maryland, provides the base from which Government scientists study the biological, physiological, and behavorial changes that take place with aging humans. In addition to its own staff of investigators, the Center provides laboratory facilities for guest workers and foreign fellows and also serves as a national facility for the study of aging. The Center's facilities and staff are frequently used resources for scientists in the community and at universities, medical schools, and other biomedical institutions throughout the country.

The primary requirement for aging studies is access to animals of known age, parentage, and exposure to infectious agents. In past years, aging research has often been hampered by difficulty in obtaining these experimental animals. In response to this need, the GRC has now developed a large colony of aging rats which are made available to qualified investigators in other laboratories.

During 1972, 12 collaborative research projects, involving some 50 guest scientists and supporting personnel, operated at the Baltimore Center. In addition to modern scientific equipment and senescent animals, the Center's resources include an extensive gerontology library, temperature control rooms useful for studying the effects of environment on aging, tissue culture facilities, up-to-date electronic data processing equipment, an animal surgery suite, regular research seminars, and special conferences on aging.

Investigators from many disciplines study what happens to people and animals as they age, how older organisms adjust to aging, and what might be done to slow or prevent some of the harmful effects of aging.

Studies which compare measurements made on a group of young subjects with those made on a different group of old subjects may lead to erroneous conclusions about aging because the old subjects could represent survivors who were superior individuals in their youth. Studies using statistics based on data averaged from subjects of different ages do not necessarily show the progression of age-caused changes. In order to determine the interrelation between aging in different organ systems it is necessary to obtain serial measurements on the same individual. These measurements are essential if gerontologists are to find out whether there is a general aging factor, or whether aging is simply the result of random deficits that develop in different patterns in different people. A principal activity of the GRC is the conduct of the Baltimore Longitudinal Study. This study is an effort to obtain a detailed understanding of aging in humans by making repeated observations on the same individual as he ages. A sample of some 600 men, leading successful and active lives, has been recruited for this study. Primarily from the Baltimore-Washington area, all subjects are volunteers ranging in age from 20–96 years. Each subject in this study spends two and one-half days at the Gerontology Research Center every 18 months. At each visit these volunteers are given extensive clinical, biochemical, physiological, and psychological tests to measure age changes.

Investigators interested in nutritional aspects of aging are participating in the Study. Recently, these scientists, working in collaboration with nutritionists at Philadelphia General Hospital and the Hoffman-LaRoche Company, have collected data on the vitamin status of the 600 volunteers.

Early results from this study show that with advancing age even well-nourished men are deficient. Of the 200 men studied to date, 30 percent take a vitamin supplement to their diet on their own initiative. As measured by the amount excreted in urine, one-fifth of the subjects not taking vitamins show evidence of abnormally low levels of thiamine (B_1) and riboflavin (B_2). At least half of these older men show a deficiency of pyridoxine (B_6) in blood plasma. Not only do the men have low vitamin levels, but also there is evidence of abnormal enzyme levels in the plasma and in the red blood cells of those not taking vitamin supplements.

These early results are surprising because the group under study is made up of highly educated, successful, community-living subjects who have access to adequate diets. On the positive side, chemical evidence of vitamin B deficiency is rare in the middle-aged and in those elderly subjects who, without direction, include a vitamin supplement in their diets.

In a different GRC laboratory, a guest investigator is studying still another vitamin which sometimes is found to be deficient in older people. This vitamin, folic acid, is essential for the formation of new cells in the body.

Early results indicate that there is a significant difference in rates of folic acid absorption in the small intestine of young rats (6-weeks old) compared to old rats (2-years old). A 2-year-old rat is roughly comparable to a 70-year-old man.

If the age-related difference in absorption rates observed in these early experiments continue to be observed as more animals are studied, then scientists may pursue similar human studies. It is possible to theorize that some of the vitamin deficiencies seen in older humans might result from age related defects in vitamin absorbing capability of the intestine.

LEARNING ABILITY AMONG THE AGED

Still other GRC investigators have been studying the verbal learning ability of participants. Recent analyses of data show that when material to be learned is presented visually at a fairly fast rate, the subjects make increasingly more errors as they grow older.

These results are consistent with the finding based on cross-sectional analyses that there is an age dependent decrement in verbal learning performance. In a cross-sectional study, people of various ages are tested once and only age differences between individuals can be measured. In the longitudinal study, each person is tested initially and then retested approximately six years later, thus providing a measure of change in performance with age. The verbal learning procedures used at the Center require the acquisition and recall of new information, whereas intelligence tests tap old information. In contrast to verbal learning performance, intelligence tests have demonstrated no age-related changes in mental ability. In view of the disparity of results between the two measures of intelligence, further studies of the relation between mental ability and age are required.

It is important to note that the magnitude of the age-related decline in verbal learning performance varies with the rate at which material to be learned is presented. Under conditions where material to be learned is presented at a slower speed, the decline with age is much less marked and tends to show up much later in life.

BIOLOGICAL ASPECTS OF AGING

Age-related deterioration of the body's immune response to invasion by foreign proteins is thought by many to be responsible for the increased susceptibility to infections and to cancer in the elderly. Researchers have observed a marked loss of immunological responsiveness in aging humans. Studies have shown that the defect in immunological competence is located in the immunological cells of the aged animal. The immunological system is made, at least in part, of cells formed in the thymus gland (T cells) and the bone marrow (B cells) that are capable of producing the active disease fighters. These T and B cells concentrate themselves in the spleen and lymph nodes or travel through the body with white blood cells.

When an infectious organism (an antigen) enters the body, a team of these cells work to destroy the invaders. In early infancy this immune system receives assistance briefly from maternal antibodies transferred during pregnancy. The activity of this system reaches its peak during adolescent years then decreases as the animal ages.

It has been suggested by some experts that cells become different genetically with time. When this happens they can become antigenic and stimulate a response

by the body against its own cells. This results in an autoimmune disease harmful or deadly to normal cells. The aging and cell death that follows represents the end result of an autoimmune process and an active immune system gone awry.

Immunologic techniques perfected over the past few years now make it possible to initiate new research efforts to identify changes in the immune system with aging. In recognition of this fact, NICHD in the fall of 1972 established a special Section on Immunology within the Gerontology Research Center's Laboratory of Cellular and Comparative Physiology.

Seven outstanding immunologists have been recruited as the nucleus of the new section. These investigators are initiating studies on the mechanisms of the age-related decrease in immune responses in both animals and humans. In addition, they are conducting studies to determine the role of the autoimmune response in aging and to find out how cells distinguish between cells of their own kind and foreign invading bodies. The extramural Adult Development and Aging Branch is also supporting studies of the immunological aspects of aging.

CELLULAR AND MOLECULAR AGING

Old animals take more time than do young ones to produce certain enzymes, although they eventually do produce appropriate amounts. This means that while the older animal can perform a particular metabolic task it takes him much longer.

Recent studies by scientists in the GRC Laboratory of Molecular Aging have shown that impairments in the body's cell control mechanisms lessen the ability of old animals to produce certain proteins, essential to the maintenance of life. This means that aged cells can produce enough essential proteins if they are properly stimulated and if the materials needed for the protein production can be delivered to the cells.

Research in this area is aimed at experimental introduction of new materials into cells to repair or counteract the effects of age. An investigator in the GRC Laboratory of Molecular Aging has synthesized new compounds (polymers) that can penetrate cell membranes without destroying the cell wall and disrupting the whole cell. (Previously scientists depended on living organisms, usually special viruses, to get into the cells.) Under normal circumstances it is extremely difficult to introduce substances such as hormones, enzymes, or genetic material (nucleoproteins) into the cells. Now, with the synthesis of the polymers it may be possible to introduce these large molecules into the cells by attaching them to the polymers.

The polymers used at the GRC have been designed, produced, and evaluated for their ability to simulate protection against viruses. A Center investigator has also found that the antiviral defense mechanisms of human cells grown in tissue culture change with age. The viral protection induced with chemicals is most effective in the middle of the *in vitro* (cell culture) life span, then decreases sharply but is still functional up to the last 10 percent of the cultured cell's life span.

Extramural Research and Training Programs

The history of medical practice has shown a movement from intervention during medical crises toward the prevention of crises. The earliest results of this shift in strategy were studies in the prevention of diseases due to infectious agents and nutritional deficiency.

Today the philosophy of prevention can be seen even in basic studies designed to isolate and characterize risk or predisposing factors—the modification of which can prevent the development of overt disease. An important tool for this type of research is the longitudinal study. NICHD longitudinal studies in Baltimore, Durham, N.C., Boston, and Berkeley are being applied to analysis of the various types of deterioration that occur in the aging human. The Durham study has resulted in increased appreciation of the role hypertension plays in deterioration with age and particularly in the decline that may occur in mental function. This decline is a problem which is not only devastating to the elderly, but also to their families and to society. Longitudinal studies have also contributed greatly to our knowledge of metabolic changes that occur with increasing age. We have learned that energy requirements decrease; the ability to convert carbohydrates to energy declines, and the ability of the body to regulate levels of blood lipoproteirs (fat carrying proteins) is disturbed. All these changes have significant implications for health and functional ability.

A series of studies of former college students by NICHD grantees has identified four characteristics that when present at college age predispose the men in later years to fatal strokes, hypertension, and fatal and nonfatal coronary heart disease. These factors—higher than normal levels of blood pressure, overweight, short height, and cigarette smoking—were also recently identified by the grantees as risk factors for nonfatal stroke.

Certain characteristics of aging men were also found to be associated with an increase in stroke. These were: high blood pressure (which had also been a predictor at college age), coronary heart disease, diabetes, and a history of parental high blood pressure. High blood pressure in later life had the greatest effect on the incidence of stroke, and, along with a family history of high blood pressure, was a better predictor of nonfatal stroke than high blood pressure at college age. A comparison of these findings with those of fatal stroke showed that the predisposing factors were the same.

Many of the deteriorative processes that occur with age cannot yet be treated effectively. The menopause—a condition occurring in middle-aged women—is an outstanding exception to this. It is due to a decrease in the secretion of hormones by the ovaries. Some degenerative processes that occur in women after the middle years are definitely known to be due to this hormonal decline. It is clear that hormonal replacement reverses the unfortunate changes, but much remains to be learned about what constitutes optimal therapy, what effect it has on many aspects of health, and what side effects it may have. NICHD-supported studies are designed to determine what is occurring in menopausal and postmenopausal women and what the good and bad effects of hormonal replacement therapy are.

Studies of humans as they age and studies of preventive and therapeutic intervention are invaluable, but progress can be slow. Scientists are hampered because certain experimental procedures are inappropriate on humans and because the human life span is too long to permit rapid results. As a result, scientists look to experimental studies in animals for the relatively rapid acquisition of knowledge about aging that can then be tested in appropriate ways in humans. For some time now, scientists have considered rodents to be the most appropriate experimental animals, although breakthroughs resulting from studies with other animals may occur. The advantage of rodents are that they can be raised relatively cheaply, have short life spans, and are similar to humans in several ways.

NICHD maintains colonies of special research rats and mice both in its intramural program and by contract with commercial breeders. Studies are showing that preventing infection of the animals by bacteria prolongs the average length of life but does not prevent deteriorative aging changes.

Evidence suggests that lifelong nutritional habits are of great importance to health and longevity and rodents maintained free of infection provide ideal subjects for nutrition research.

In addition to using animals to study the decline of the body's defense system, NICHD grantees are using them to investigate the speed with which the cell's enzymatic machinery can respond to stimulation by hormones and other agents. The speed of response decreases greatly with age and may partially explain the inability of the older person to respond to stresses initiated by these agents. This, in turn, results in vulnerability to disease and/or reduced functional ability.

Many of the deteriorative changes associated with increased age probably have their origins in the cells. This idea, although not new, is just now receiving support in the form of definite evidence. There are two schools of thought on the mortality or immortality of human cells. These theories are that normal human cells grow, are immortal, and that if they die, their death is the result of some environmental influence. The other theory is that cells have an aging process and that death is inherent in their genetic "program."

Studies of human cells in culture conducted by an NICHD grantee have introduced further evidence to support the theory that the cells themselves are mortal. By studying human figroblasts (cells from connective tissue) the investigator observed that the fibroblasts are not capable of indefinite survival even when removed from the body and maintained in tissue culture or transferred surgically to one young host and then another. Neither the ideal environment of the tissue culture system or the youthful host organs could keep the cells indefinitely reproducing.

Another investigation of aging at the level of the individual cell makes use of sophisticated biochemical and biophysical techniques to determine the mechanisms by which pigments accumulate in many cells with increasing age. These pigments, which are leftover fatty material, are darkly colored and are probably metaboli-

cally inert. Pigments occupy a large fraction of the volume of many cells and may interfere with cell function. Although known as aging pigment this is not the same material which appears on the skin as age spots.

A need of those responsible for caring for the elderly is knowledge of what professional home nursing care has to offer older persons. Recent studies by NICHD grantees have shown that among a group of mild to moderately disabled elderly patients, those given home nursing care were less likely to deteriorate physically and mentally and were also less likely to be admitted to nursing homes.

In contrast, the grantees observed no significant differences in the deterioration of mental and physical functions between severely disabled patients who received home nursing care and those who did not. What home nursing care did do for the severely disabled was to increase their use of medical, paramedical, and social services.

These findings suggest that health professionals should be trained to recognize what response to treatment can be expected with different degrees of disability. While a visiting nurse can expect to maintain or improve the physical and mental functions of moderately disabled patients, her role in ministering to severely disabled persons is that of simply coping with the patients' everday needs and periodic crises. The findings also suggest that in the case of severely disabled patients, manpower could be used more efficiently if the role of coordinator of services was delegated to less highly trained personnel, in effect freeing the nurse to devote more time to rehabilitative treatment.

Additional alterations in the size and structure of the population will occur. Clearly, prolongation of life will alter the patterns of illness and death in this country. Death rates are not, however, the only determinants of the age-structure of the population. Factors such as changes in birth rates and migration habits also influence the structure and necessitate the development of complex mathematical model systems and intricate computerized computation for the accurate prediction of our future status and health needs. NICHD is supporting by contract research to evaluate the usefulness of existing mathematical model systems with an eye to modifying such models or having new ones created to serve the new needs.

ITEM 18. SMALL BUSINESS ADMINISTRATION

DECEMBER 29, 1972.

DEAR MR. CHAIRMAN: This will reply to your letter of December 15, 1972, requesting a statement on the Small Business Administration's activities for older Americans.

Although SBA's usual activities are not directed at the problems of the aged as such, one legislative development in 1972 may be of interest for the Committee's report.

SBA, among other agencies, is involved in the rehabilitation of property damaged or lost as a result of disasters such as the Rapid City, South Dakota floods and Hurricane Agnes. This rehabilitation is done through low-interest SBA loans, the principal of which is cancelled up to a maximum of $5000 under current law. Since loan amounts above $5000 must be repaid, this may sometimes make problems for older Americans living on limited retirement income, e.g., Social Security payments.

Public Law 92-385, approved August 16, 1972, authorizes for a limited period additional loan assistance under the Small Business Act for disaster victims. It provides in part that SBA may, in connection with loans for the rehabilitation of "property owned and used as a residence by an individual who by reason of retirement, disability, or other similar circumstances relies for support on survivor, disability, or retirement benefits under a pension, insurance, or other program, consent to the suspension of the payments of the principal of that loan, mortgage, or lien during the lifetime of that individual and his spouse for so long as the Administration determines that making such payments would constitute a substantial hardship."

The effect of this provision is to allow suspension, for the lifetime of the borrower and his spouse, of repayment of principal on home loans. Repayment of the loan is made possible by the ability of SBA as mortgagee to sell the property eventually.

Sincerely,

THOMAS S. KLEPPE.
Administrator.

ITEM 19. SOCIAL AND REHABILITATION SERVICE

ACTIVITIES AFFECTING THE ELDERLY DURING 1972

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 has been 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. Rehabilitation services are provided older disabled persons as well as the disabled of other ages. SRS's Community Services Administration brings together under unified direction the provision of social services to individuals and families, including the aged. SRS research and demonstration activities provide needed information and understanding regarding the elderly, as well as other age groups. These various aspects of work of SRS are discussed in this report.

Old-Age Assistance

In June 1972 SRS's Assistance Payments Administration served 2,025,000 persons aged 65 or over through the old-age assistance program. While this is only a slight decrease in number from the preceding year it represents a marked decrease from the all time 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.

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 1972 was $78.12.

According to the latest study available the median age of old-age assistance recipients is approximately 76 years. The proportion of assistance recipients living alone in their own homes is approximately 39 percent. About 3 in 10 OAA recipients received one or more social services. 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, 41 States now provide for a disregard of some portion of earned income in determining the amount of assistance payments. Additionally, 26 States allow for some disregard of income which is incurred from sources other than earnings.

Medical Assistance

During 1972, the Medical Services Administration further intensified its activities to develop alternative modes to institutional long-term care. As the result of a grant from the Medical Services Administration awarded in June, 1971, to the Development Education and Training Research Institute (DETRI) of American University, a project was undertaken entitled "Long Term Institutional Care and Alternative Solutions." The American University Project developed and catalogued data on long term care needs and resources, and identified 37 outlines of potential demonstrative concepts and components to be used in testing the feasibility of a wide variety of non-institutional approaches to care. In April, 1972, as part of the study, a multi-disciplinary group of selected experts in the long term care field was drawn together to develop the best strategies for reducing reliance on institutions for care of the aged and chronically ill. Building on the components developed by the research group, this group developed about 23 models of service delivery systems designed to improve health care and to avoid or delay institutionalization.

The Office of Program Innovation, Medical Services Administration, in collaboration with the Office of Research and Demonstrations, SRS, selected two of these demonstration models for fiscal year 1972 funding and invited proposals. The models selected were "Day Hospital," and "Day Care Center." There is little experience in this country with these alternatives to institutional care, yet there is evidence in other countries, especially Great Britain, that the Day Care approach is promising and effective for the elderly. Subsequently, four projects were funded—one "Day Hospital" and three "Day Care Centers."

The "Day Hospital" is being conducted by the Burke Rehabilitation Center in White Plains, N.Y., and is jointly funded by AoA ($170,000) and MSA ($124,017).

*See item 2, p. 141, The Administration on Aging—1972.

The project will offer a choice between home care and institutionalization and attempt to postpone the time elderly people in the area will have to be institutionalized.

The three "Day Care Centers" are:

"On Lok Health Services" is being conducted in San Francisco, by the Chinatown-North Beach Health Care Planning and Development Corporation in San Francisco. This project is jointly funded by AoA and MSA.

"Day Care Center for the Elderly," a project jointly funded by AoA and MSA, is being carried out by the Center for Community Research of the Associated YM-YWHA's of Greater New York, under the auspices of Montefiore Hospital and Medical Center, Bronx, New York.

"Levindale Geriatric Day Care Center Project," which is administered by Levindale Hebrew Geriatric Center and Hospital, Baltimore, Maryland, is funded solely by AoA.

As of December 31, 1972, there were 6,600 certified Skilled Nursing Homes. Approximately 33% had twelve months provider agreements and approximately 67% had six months provider agreements. The Certification Objective for July 1, 1972, resulted in approximately 500 homes which were either decertified or voluntarily withdrew from Medicaid participation. 28,000 patients were affected and were either relocated to other certified Skilled Nursing Homes or Intermediate Care Facilities (ICF) based on a review of their needs.

The deadlines set by the Secretary for State fulfillment of Federal certification requirements for Skilled Nursing Homes has been met. By February, 1972, all States had to reform certification procedures, and by July, 1972, they had to inspect all nursing homes to be sure they complied with Federal standards.

Effective January 1, 1972, care in Intermediate Care Facilities was transferred from the cash public assistance titles to Medicaid (Title XIX). By the end of the year, forty States had included ICF care in their Medicaid programs. The effect of the transfer of the ICF program to Medicaid will be to raise the standards of care in these institutions.

Medical Services Administration is in the process of revising regulations governing home health services under Medicaid in order to expand services to recipients in their own homes and prevent unnecessary institutionalization.

Rehabilitation Services

The Rehabilitation Services Administration's program for the Aging has as its primary goal the rehabilitation of as many older handicapped individuals as possible into gainful employment through the State-Federal vocational rehabilitation program.

The agency's program endeavors to assist each individual to reach his most adequate functioning level and highest potential. This is accomplished through a diagnosis of his condition followed by various services designed to overcome his specific handicap. Throughout the process, the emphasis is on helping the individual to help himself. These services include evaluation and medical diagnosis to determine the nature and extent of the disability and to ascertain capacity for work, counseling to help in developing a good vocational plan, medical care to reduce or remove the disability, vocational training and placement into employment, and follow-up to ensure satisfactory placement.

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 handicapped 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.

In an effort to alleviate this situation, State rehabilitation agencies have been intensifying their efforts to serve the aged handicapped and an increase in the number of these individuals served as resulted. For example, in 1970 a total of 266,975 persons were rehabilitated into employment 67,738 of whom were aged 45 and over and of this number 4,245 were aged 65 and beyond. In 1972, a total of 326,138 handicapped persons were rehabilitated by State rehabilitation agencies of whom it is estimated 80,100 were 45 years of age and over, of this figure it is estimated 4,800 were 65 years of age and over.

State rehabilitation agencies have utilized expansion grants and basic support resources to increase their services to 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. Also, the Ohio rehabilitation agency has participated in a public housing project for the handicapped and senior citizens.

Currently, three expansion grant projects are in operation focused on rehabilitation of the aged disabled on, or near, the poverty level into employment. Public welfare recipients are also included in this grouping. These projects are located in New York, Illinois and Massachusetts.

Shirt-Term Training Grants have also been used effectively by RSA in developing services for the aging. This resource was used to conduct a course on orthopedics and gerontology in cooperation with the American College of Orthopedic Surgeons. The purpose of this course was to introduce young surgeons to surgical techniques that had proven effective with the older patient needing orthopedic surgery.

Two Short-Term Training courses are being developed and will be conducted in the near future. These will be Regional Short-Term courses and will focus on implementation of recommendations on rehabilitation of the aging voted upon by delegates in the 1971 White House Conference on Aging.

The Rehabilitation Services Administration cooperates with the Administration on Aging in various activities such as Senior Citizens Month and other special projects and will continue to do so.

Community Services

In 1972 through Federal-State programs operating under the authority of the Community Services Administration services for the aged continued to expand. Continuing use was made of services obtained through approved purchase arrangements when public welfare agencies felt they could more effectively provide services for eligible individuals through use of other agencies' resources. Assistance in obtaining and using medical care and services needed to remain in the home or necessary for return to community living from an institution were the major kinds of welfare social services.

Federally-funded demonstration projects, particularly those using 1115 money allocated to public assistance, were ongoing. A number incorporated outreach efforts, consumer information and utilization of health resources at the local level for welfare and low income groups, including the elderly. Wider involvement of neighborhood workers and subprofessionals showed the effectiveness of their participation. A common finding from projects offering social services associated with medical care emphasized the importance of a helper or advocate, especially for those of advanced years.

It is not possible for many elderly to obtain access to the present complicated medical delivery system and to realize the intended benefits unless they have a reliable intermediary. The role of the Intermediary was chiefly found to be that of giving clear information about health benefits and how to obtain them, with frequent personal help rendered with the latter. Escort service, arranging transportation, and consistent follow-through to assure that medical recommendations were understood and carried out were also identified as major supportive activities.

Fulton County as part of the Georgia State Department of Family and Children Services operated a successful "Housing Aid to the Aged" demonstration in Atlanta. Professional and subprofessional staff look for suitable housing, help clients move to new housing or have present housing improved, assist with better home management and arrangement, and also search for other elderly needing better housing.

The Community Services Administration during 1972 developed a new approach to service delivery. The new social services system will benefit older adults as well as other needy groups. The system concentrates on the removal of barriers which preclude vulnerable individuals from maintaining or attaining maximum capacity for financial and personal independence. These goals will be accomplished through a system of integrated services to meet clients' specific needs. The goals are:

1. Self-support, directed toward services to enable the individual to become partly or fully financially independent.
2. Self-care or family care including services to enable an individual to care for his personal needs.

Service delivery may emanate from a comprehensive service center or arrangements may be made to link available resources into a service network. Other types of planning may be used in order to accommodate local circumstances.

Within SRS, as part of a Department-wide effort, increased attention and cooperation have been given to joint endeavors to postpone or prevent unnecessary institutionalization of the elderly and to reduce the period of institutional care by developing more suitable alternative living arrangements in the community. The planning cycles for fiscal year 1974 for CSA, MSA, and AoA are being coordinated in order to make maximum impact on this problem.

A related activity has been CSA participation on the NIMH Task Force which planned several Federally-funded nursing home ombudsman demonstration projects. Testing the use of an ombudsman for patients in nursing homes is part of President Nixon's Nursing Home Program and will undoubtedly provide new and significant findings on the needs of this vulnerable population.

The final passage of HR 1 on October 30, 1972 intensified CSA staff work in planning for the consequences of the January 1, 1974 replacement of present Social Security Titles I, X, XIV and XVI by the new titles XVI—Supplemental Security Income for the Aged, Blind, and Disabled, and VI—Services for the Aged, Blind or Disabled. The latter will be derived from the general revenue and administered by the Social Security Administration. CSA will issue revised regulations and guidelines outlining the process by which SSI recipients are informed about the social services they can receive through State departments of welfare. Linkages between these separate but related programs will be developed. The necessary collaboration between CSA and related units of the SSA has begun.

The "State and Local Fiscal Assistance Act of 1972," which limits the amount of Federal funds available to the States for Social service expenditures, will result in the redirection of the scope of social services provided by State programs. CSA will continue to work with the States in developing program models to meet the needs of the increasing numbers of the aged needy. Preventive and supportive measures during old age yield both personal and cost-benefit advantages.

The National Center for Social Statistics (SRS) in September 1972 published "Findings of the 1970 OAA Study, part 1, Demographics and Program Characteristics," which contained comparisons with the result of a similar 1965 study. There were no wide differences in age, marital status, or housing arrangements, though the number of elderly living alone rose from 35 to 38.6 percent. The size of the Old Age Assistance caseload was approximately the same for both years; 2,151,000 in 1965 and 2,033,000 in 1970 (excluding Arizona and Guam). In 1970, 62.6 percent had one or more chronic health conditions. Circulatory diseases (31.7 percent) and arthritis (29.8 percent) were the most frequent diagnoses; all others were 7 percent or less. Impaired vision or impaired hearing were 9 percent and 8.6 percent respectively.

About three in ten received one or more social services during 1970; 18 percent related to physical functioning, and nearly 2 percent were associated with mental functioning. Other kinds of social services were very diversified.

Public Affairs

SRS's Office of Public Affairs produced five 16-mm. color films which are available through the National Audiovisual Center for sale or on a free loan basis. One of them was a 30 minute film especially designed for television use, on Aging needs and programs, which was produced following the White House Conference on Aging. There were several hundred film showings of it for public and television audiences during 1972.

In addition, the Office of Public Affairs produced one 60-second television spot announcement, stressing the importance of coordinating community services, for national distribution, and two 60-second radio spots on the theme of ending isolation of the elderly by using their skills in the community. One television show on Aging was produced with NBC in its "No Place Like Home" series, to be aired in 1973.

The SRS Magazine, HUMAN NEEDS, published a display advertisement on information available to elderly persons who want to continue to be productive after retirement.

The Office of Public Affairs provided assistance to AoA in news releases, publications, speaking engagements, and news conferences.

Research and Demonstrations

The SRS research and demonstration grants program supports a variety of projects which seek to provide new knowledge about the status and problems of elderly people. Although the primary source of funding for R & D projects in aging is Title IV of the Older Americans Act, some are also supported under Sections 1110 and 1115 of the Social Security Act. Others are supported jointly by SRS and other federal agency programs, particularly the National Institutes of Health.

Title IV of the Older Americans Act provided grants for approximately 20 new projects for the study of problems of elderly people and the delivery of services to them during calendar year 1972. The major priority guiding the selection of studies or demonstrations of applied knowledge was returning or maintaining vulnerable elderly in their own homes or appropriate community settings. Building on substantial research in progress, the Office of Elder Affairs in Boston began a demonstration of community-based home care programs of coordinated health, social, and other support services. These home services draw on the same source of funds now being used to pay for institutional care (Medicaid), and it is hypothesized that a more desirable, more efficient and less costly option can be provided for elderly who are currently being placed in nursing homes and other institutional settings. This project is also supported by the National Center for Health Services Research and Demonstrations of the Health Services and Mental Health Administration and by a Medical Services Administration waiver to permit use of Medicaid funds.

Four projects are studying the problem of day care services for elderly people who without such services would be institutionalized or those who could be returned to community living if such services were available. The program of the Chinatown-North Beach Health Care Planning and Development Corporation in San Francisco is directed at three ethnic minority groups—Chinese, Filipino, and Italian. This project is supported by Title IV and Section 1110 funds. The Levindale Hebrew Geriatric Center and Hospital in Baltimore seeks to produce findings which would lead to changes in Medicare-Medicaid legislation which underwrite health care predominately within an institutional setting. The project sponsored by the Burke Rehabilitation Center in White Plains, New York, is focused on day care services within the context of total community services and linked to an information and referral system; it is also supported by Title IV and Section 1110 funds. Montefiore Hospital in New York City is evaluating day care services with funds from Section 1110.

Other parameters of the problems of alternatives to institutional care are being explored in the following ways. The Colorado Department of Institutions, Denver, is testing the feasibility of specialized boarding homes for elderly persons who have had or continue to have mental problems. This approach holds promise for lower cost and more effective alternative to nursing homes, mental hospitals, or in-patient psychiatric hospitalization. It is jointly supported by Title IV and HSMHA through the National Center for Health R&D. The Family Service Association of America, with support from Title IV and NIMH, is undertaking to strengthen the quality and expand the scope of programs for the aging in local family service agencies, with the overriding objective of enhancing programs which will enable the elderly to remain in their own homes through these psychological and tangible supports which maximize independence. A manual for training homemakers in home care for the elderly is being developed by the National Council for Homemakers Service, while the National Center for Voluntary Action is developing program guides for voluntary organization use in establishing home service programs for the elderly. In the religious sector, the National Interfaith Coalition on Aging, Athens, Georgia, is examining programs for the aging and information systems about services for the elderly, with the goal of improving correlation of public and private efforts for the older adult population.

A number of Title IV projects are directed at filling existing knowledge gaps and at examining neglected problems in a variety of areas. All of these areas have significant implications for the vulnerable, institutionalized, and minority elderly. The potential for translating electronic and technological advances into care for the elderly is being examined by the Illinois Institute of Technology, while Interstudy of the American Rehabilitation Foundation is investigating the potential for use of cable TV in an information and referral system.

The Massachusetts Secretary of Elder Affairs, with support from Title IV and HSMHA, is experimenting with a Nursing Home Ombudsman program to im-

prove the quality of care received by patients within nursing homes. Montefiore Hospital in New York City is evaluating the effectiveness of brief psychotherapy to the bereaved aged, while the New York State Department of Mental Hygiene is developing refined measures for the detection of psychopathological conditions in the elderly and identifying implications for treatment. At the University of Chicago, a brief instrument that is valid and reliable for measuring personality characteristics in middle-aged and older people is being developed, with an analytical description of the dimensions of personality most significant in the prediction of psychological well-being in older people. In the area of minority emphasis, the Montana United Indian Association is studying the nature, type, and extent of problems and needs common to elderly urban Indians. The University of Pennsylvania is assessing the impact of the flood damage in Wilkes-Barre on elderly people, and seeking to determine the responsiveness of service agencies to crisis. With Section 1115 funds, the WCGH Health Care Program for the Inkster Community, Michigan, is providing outreach to elderly public assistance recipients for medical services.

Other activities entered into during calendar year 1972 include a strategic exploration of national policies affecting the elderly and construction of data-based predictions of the future, given present policies or alternative policies. This work is being done by the Stanford Research Institute. The Oregon State Legislative Interim Committee on the Aging is undertaking to develop a legislative strategy to meet the service needs of the elderly which fall between existing programs and White House Conference goals. The University of Southern California Gerontology Center is organizing, evaluating, and analyzing research data, concepts, theories, and issues on the biological, psychological, and social aspects of aging for publication in three volumes of Handbooks in Gerontology. These Handbooks will organize available information on aging for purposes of teaching, research, policy development, program planning, and application. The Gerontological Society began work on state-of-the-art papers on key social policy needs, possible different solutions, and the kinds of research, development, and information that would be useful in making policy decisions responsive to such needs and issues.

Important work begun in earlier periods was continued in 1972. In particular, social service and nutrition projects in Illinois and Florida made progress. The Florida project is co-sponsored by Title IV and Section 1115. Title IV continued to support a state-wide information and referral demonstration in Wisconsin, and several transportation and mobility demonstrations. Section 4A of the Vocational Rehabilitation Act continued support of research on transportation for the elderly and handicapped in the Naugatuck Valley of Connecticut, as well as a study of the supply and demand of jobs suitable for older workers being carried out by the Human Resources Center, Albertson, New York.

Continuing demonstration projects funded under Section 1115 for elderly recipients of public welfare included housing assistance in Eastern Kentucky and Georgia, consumer affairs assistance in Georgia and Michigan, delivery and coordination of services in Florida and New Jersey, homemaker and home management services in Washington, Virginia, Montana, Utah, Florida, and Tennessee. Other 1115 projects involve aged welfare recipients in pre-paid health insurance plans and health maintenance organizations.

Several studies of intermediate housing as an alternative to institutional care begun in 1971 made substantial progress in 1972. Final reporting was made on the social indicator study carried out by Interstudy of the American Rehabilitation Foundation, and a preliminary report was made on the state planning study being carried out by Brandeis University.

ITEM 20. SOCIAL SECURITY ADMINISTRATION

FEBRUARY 28, 1973.

DEAR MR. CHAIRMAN: In further reference to your letter of December 15, we are happy to enclose the attached statement summarizing activities of the Social Security Administration in 1972 for older Americans. We look forward to your Committee's "Developments in Aging—1972" report.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

[Enclosure]

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 (for a period specified in the law) the "black lung benefit" provisions of the Federal Coal Mine Health and Safety Act of 1969. (Beginning in 1974 it will administer the Federal supplemental security income program for the needy aged, blind, and disabled.) 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.

About 96 million covered workers contributed to Social Security in calendar year 1972. Today, 95 out of 100 mothers and children are protected against loss of income because of the death of the family breadwinner. The survivorship protection alone, as of January 1, 1973, had a face value of $1,750 billion.

DEVELOPMENTS IN SOCIAL SECURITY IN 1972

LEGISLATION

Public Law 92–336, signed by President Nixon on July 1, 1972, provided, effective for September 1972, a 20-percent across-the-board increase in monthly cash benefits, including the special payments to certain persons aged 72 and over; it provided, in addition, for automatic benefit increases in the future as prices rise. It also raised the earnings base for contribution and benefit purposes from $9,000 (the 1972 base) to $10,000 in 1973, and $12,000 in 1974; the base will be raised automatically thereafter as wages rise.

Public Law 92–603, the Social Security Amendments of 1972, signed October 30, included major changes in the retirement and survivor provisions of the Social Security Act that (1) raise the benefit amount for widows and widowers who become entitled at age 65 to 100 percent of the spouse's benefit; (2) provide for the use of age 62 as the computation point for men's benefits, as for women; (3) raise to $2,100 the annual exempt amount of earnings without benefit loss and provide for future automatic adjustments; (4) provide a special minimum benefit for persons with long years of coverage at very low earnings; and (5) permit nondisabled widowers to choose reduced benefits at age 60.

The contribution rate schedule in the law calls for an employee-employer contribution of 4.85 percent (each) of covered earnings in 1973–77 for monthly cash benefits and of 1 percent for hospital benefits under Medicare.

The amendments added a new Federal supplemental security income program for the needy aged, blind, and disabled to be administered by the Social Security Administration; existing legislation for the Federal-State assistance programs for these groups is repealed effective January 1, 1974. The new program will pay $130 per month to an individual ($195 to a couple) if monthly income, as defined in the law, is less than the full monthly payment. A State may supplement the Federal benefits, and such State payments will be excluded as income for purposes of the Federal program.

The amendments included substantial changes in Medicare that (1) increase the medical insurance deductible to $60; (2) extend the program's protection to persons entitled for at least 2 years to cash disability benefits under the social security or railroad retirement programs, and to insured persons under age 65 and their spouses and dependent children if a member of such a family requires hemodialysis or a kidney transplant; (3) allowed those eligible under Medicare for both hospital and medical insurance, or for medical insurance only, to use health maintenance organizations for their health care needs; (4) permitted those reaching age 65 and ineligible for hospital insurance to enroll voluntarily, as for medical insurance, and pay the full cost of the protection; (5) provided payment of 100 percent of reasonable costs for home health services under medical insurance; and (6) allowed, under medical insurance, coverage of certain services of physical therapists and chiropractors.

BENEFICIARIES AND BENEFITS

Some 27.8 million men, women, and children had Social Security benefits in current-payments status as fiscal 1972 ended—an increase of 1.1 million over a year earlier. These beneficiaries included about 17.5 million retired workers

and their dependents, 3.1 million disabled workers and their dependents, and 6.6 million survivors of deceased workers. Also included were 439,700 uninsured persons aged 72 and over whose Social Security payments were financed primarily out of general revenues. Ninety-one percent of the population aged 65 and over were receiving benefits at the beginning of 1972 or would be eligible to receive benefits when they or the spouses retire. Of those who reached age 65 during 1972, 93 percent were eligible to receive cash benefits. Projections to the year 2000 indicate that 97 percent of all aged persons will then be eligible for cash benefits under the program.

During fiscal year 1972, benefits paid under the retirement, survivor, and disability provisions of the program totaled $38.6 billion; of that amount, $322.3 million represented lump-sum death payments. Benefits to retired workers and their dependents and to survivors totaled $34.5 billion—10 percent more than the 1971 total, and benefits to disabled workers and their dependents reached $4 billion—up 20 percent from the preceding year. The monthly rate of benefits being paid at the end of the fiscal year—$3.1 billion—was $172 million more than the amount for June 1971.

Benefits checks for months after August reflected the 20-percent increase enacted in July. December benefits for retired workers averaged $162; for those newly coming on the rolls the average was as high as $173. Benefits going to disabled workers averaged $179, and new awards to these beneficiaries averaged $194.

"Black lung" benefits were being paid to about 190,000 beneficiaries in December 1972—a 31-percent increase from the December 1971 number that reflected the effect of amendments to the black lung program during the year. The average December benefit under the program was $199.40.

MEDICARE OPERATIONS

Approved claims under the hospital insurance part of health insurance for the aged totaled 7,200,000 during fiscal 1972. The average amount reimbursed was $825 per extended-care claim. The hospital benefits are financed by contributions paid as part of the total Social Security contributions.

The medical insurance part of the program had 48,200,000 claims recorded for fiscal 1972. Allowed charges totaled $2.9 billion, of which $2.1 billion was reimbursed. The program is financed by monthly premiums paid by those electing to be covered and matched by the Federal Government. The premium was $5.60 during the first 6 months of 1972, rose to $5.80 in July 1972, and will remain at that rate through June 1973.

ITEM 21. SPECIAL ASSISTANT TO THE PRESIDENT FOR CONSUMER AFFAIRS

FEBRUARY 16, 1973.

DEAR SENATOR CHURCH: I am enclosing a report on the activities of the Office of Consumer Affairs during 1972 relating to the aging.

Pursuant to the President's request, the Office of Consumer Affairs has focused particular attention on the consumer problems of elderly Americans. Consequently, it is a pleasure to lend our efforts to the Special Committee on Aging in preparing "Developments in Aging—1972."

Sincerely,

VIRGINIA H. KNAUER,
Special Assistant to the President
for Consumer Affairs.

[Enclosure]

REPORT OF THE ACTIVITIES OF THE OFFICE OF CONSUMER AFFAIRS DURING 1972 RELATING TO THE AGING

The Office of Consumer Affairs, through Virginia H. Knauer, its Director, and Special Assistant to the President for Consumer Affairs, advises the President on matters of consumer interest and also assumes primary responsibility for overseeing all Federal activity in the consumer field. Pursuant to the President's request, the Office of Consumer Affairs has focused particular attention on the coordination of consumer programs aimed at assisting the elderly and others with special consumer problems.

Domestic Council Committee on Aging

On July 28, 1972, the President appointed Mrs. Knauer to the Domestic Council Committee on Aging, which was created to develop a comprehensive national strategy designed to improve the quality of life, dignity, and productivity of the country's 20 million older citizens. Other members of the Committee include the Secretaries of Health, Education, and Welfare; Housing and Urban Development; Labor; Commerce; Agriculture; Transportation; and the Director of the Office of Management and Budget. Drawing upon the findings of the 1970 report of the President's Task Force on Aging, the Domestic Council Review on Aging and the White House Conference on Aging, the Committee recommends specific action programs of assistance to the aging to be implemented by individual Executive Departments.

White House Conference on Aging

In response to recommendations make by the Special Concerns Session on Elderly Consumers at the 1971 White House Conference on Aging, the Office of Consumer Affairs has undertaken several steps to make its staff and programs more responsive to the needs of the elderly. As the first step, Mrs. Knauer appointed Mrs. Dorothy Burkhardt to serve as direct liaison between the Office of Consumer Affairs and the elderly. Mrs. Burkhardt will be responsible for keeping interested elderly consumers informed of OCA activities and publications which might be of value to them. To initiate this program, participants in the Special Concerns Session were given complimentary one-year subscriptions to Consumer News, a semi-monthly newsletter published by the Office of Consumer Affairs, and follow-up reports on OCA programs aimed at assisting consumers on limited income, the elderly, the disadvantaged and minority group members.

Consumer Legislation

The Office of Consumer Affairs has had a significant role in shaping the Administration's consumer legislative program. Two major pieces of consumer legislation enacted last year that should be of great benefit to aging consumers were similar in many respects to proposals made by the Administration.

The Consumer Product Safety Act, signed into law by the President on October 27, 1972, will establish a commission to set Federal safety standards for a variety of consumer products. The aging, who are statistically more prone to household accidents than other segments of the population, and who take longer to recover from the effects of such accidents, will particularly benefit from the promulgation and enforcement of Federal safety standards.

The Motor Vehicle Information and Cost Savings Act, signed into law by the President on October 21, 1972, directs the Secretary of Transportation to conduct a study of damage susceptibility, crashworthiness, and ease of repair among competing car models. Results of this study will be made available to the consuming public to aid them in comparing these characteristics in different cars. The resulting increase in competition among car manufacturers to produce safer and more damage-resistant cars will directly benefit the aging by reducing the costs and hazards of driving. A reduction in the likelihood of serious crash damage may also serve to lower auto insurance rates, for which many elderly consumers now pay a high premium.

Mrs. Knauer also testified before the House Agriculture Subcommittee on Livestock and Grains on another matter of interest to the aging—possible ways to keep down the rising cost of meat. For consumers on a fixed income, as are many aging consumers, the problem of inflation in the price of food staples is of vital concern.

In addition to direct testimony the Office of Consumer Affairs has prepared written comments to the Office of Management and Budget on numerous items of pending legislation that would affect the aging consumer.

National Voluntary Organizations, Advisory Groups

The Office of Consumer Affairs continues to maintain very close liaison with associations concerned with problems of the aging, in particular the American Association of Retired Persons, National Retired Teachers Association, the National Council of Senior Citizens, and the National Association of Retired Federal Employees. OCA has encouraged them to develop information and educa-

tion programs for the older consumer and to inform him of his rights and the resources helpful to him. In particular, the office has assisted AARP in developing its program of establishing consumer service centers for members, and in coordinating these services with local consumer organizations. Also, it has urged these associations to encourage their members to participate in the hearings held throughout the country by the Department of Housing and Urban Development on consumer problems related to interstate land sales.

The Consumer Advisory Council of the Office of Consumer Affairs has long maintained an interest in the problems of the aging, and many of the Council's actions have been directed at problems which would be of concern to the aging. Specifically, the Council has consistently recommended that there be increased consumer input into health care planning and programs carried out under the auspices of the Department of Health, Education, and Welfare. It has urged inquiries into prescription drug pricing and encouraged generic labeling of drugs. It supported and encouraged the Food and Drug Administration to adopt the system of Recommended Daily Allowance as the sole standard for nutritional labeling of foods. (FDA subsequently adopted this standard.) The Council has consistently encouraged nutritional labeling of foods which soon will be undertaken under regulations being established by FDA.

Finally, the Council has continued to maintain very close liaison with the developments of the Post-Conference Board of the White House Conference on Aging. Council member Dr. Wilma Donahue is a member of the Post-Conference Board and Council Chairman Eunice Howe is Co-Chairman of the Study Panel on Programs, Facilities, and Services of the Post-Conference Board. These two members report regularly to the Council on consumer concerns of the aging and recommend courses of action to the Council.

Industry Relations

The Office of Consumer Affairs has always worked actively with industry to develop voluntary industry action that will be of benefit to the aging consumer. During 1972 OCA made special efforts to encourage several of the major consumer industries (carpet, furniture, home building and housing system contractors) to establish public interest advisory committees, who will work on individual and generic problems and complaints against their particular industries. One result of this effort has been industry support for OCA promotion of the use of safety glazing by home builders and contractors.

Other efforts have been directed towards: the Telephone Company to encourage development of adapters for use with hearing aid devices; retail chain stores to obtain support for standardization of useful comparative product information ("fact tags") for consumer durables; pharmaceutical companies to promote prescription drug pricing programs and encourage relaxation of state and local laws prohibiting public display of pricing information; and the food industry to adopt nutritional and ingredient labeling, open-code dating and unit pricing.

Federal-State Relations

The Office of Consumer Affairs maintains liaison with and provides clearinghouse service as well as technical assistance to state and local officials in all 50 states, Puerto Rico, Guam, Virgin Islands, and American Samoa. During 1972 OCA continued to work for effective state and local consumer laws and offices. OCA has made special efforts to point out to state and local officials the consumer problems of the aging.

OCA researched, compiled, and published, early in 1972, a comprehensive report of state and local governmental consumer action for the previous year. Innovative and effective state administrative programs and legislation enacted to assist the aging were brought to the attention of state, county and city officials through the publication *State Consumer Action—1971*. In addition, OCA has compiled a directory of currently existing city, county and state consumer offices established to assist consumers with their complaints.

Mrs. Knauer continued to coordinate the efforts of the State Attorneys General and various Federal agencies in development of effective policies dealing with multi-level distributorships and pyramid sales plans. In 1972 Mrs. Knauer also urged state officials to promote disclosure of comparative life insurance costs and continued to urge state officials to promptly enact effective state auto no-fault insurance laws, actions which should be of material assistance to the elderly.

Building on the groundwork that was laid with the 25 Federal Executive Boards (FEBs) last year in developing consumer services programs as a major theme, the Federal-State Relations Division of OCA developed a program outline that could be utilized by the FEBs to assist elderly consumers. The FEBs were encouraged to develop consumer education seminars that could be presented in conjunction with the nutrition program for older Americans; arrange person-to-person consumer counseling sessions at the group meal sites; and to inaugurate and develop consumer training programs for senior citizens whereby they could provide assistance to other elderly persons who might be homebound.

Included in the program outline were suggestions that FEBs work toward establishing a toll-free hot-line for the elderly to obtain help and information, in cooperation with state administrations on aging; work with local consumer groups and agencies and the business community in assessing special services needed by the elderly; and undertake research programs that would test the use of various sites and methods of reaching and assisting older people.

The FEBs were also encouraged to cooperate with and assist the Social Security Administration in its role of providing information on federal services to older persons and to assist in receiving their complaints.

Regulatory Proceedings Before Federal Agencies

The Office of Consumer Affairs has continued to address oral and written comments to various Federal agencies on matters of concern to the aging.

During the past year Mrs. Knauer testified in person before the Federal Trade Commission in support of proposed trade regulation rules concerning undelivered mail order merchandise and services. The problem of making mail order sellers more responsive to their customers' prepaid orders is of particular importance to the elderly and infirm whose relative immobility often forces them to rely upon mail orders as their prime source of retail purchases.

Mrs. Knauer also sent formal written comments to the Interstate Commerce Commission urging initiation of a rulemaking proceeding on questionable practices in the household moving industry. Investigation of these practices and the promulgation of rules to control abuses will benefit the many aging consumers who face long distance moves to their retirement homes.

Consumer Education

The Office of Consumer Affairs works with Federal and state agencies as well as educational organizations to stimulate the development of consumer education for all Americans. Of particular benefit to older Americans in 1972 has been OCA's technical assistance to the growing development of adult education classes in consumer problems throughout the nation.

An Approach to Consumer Education for Adults, a new publication scheduled for 1973, emphasizes the consumer problems of the elderly. Older Americans of varied geographical and cultural backgrounds also receive attention in this new publication.

Consumer Complaints

The Office of Consumer Affairs receives approximately 3,000 complaints a month, and has a policy of sending individual replies to every writer. During 1972, the Office continued its practice of requesting from the manufacturer, trade association, or retailer concerned an equitable resolution of the complaint in question.

Complaints received from elderly consumers during 1972 were primarily in the following major categories: cost of living/inflation; drugs (cost); food prices (also quality, packaging and labeling, additives); hearing aids; home repairs; insurance; mail orders; medical services (cost); mobile homes (inability to obtain repairs); television repairs; and taxes.

Product Information

Under Executive Order 11566 entitled Consumer Product Information, the Office of Consumer Affairs provides continuing policy guidance relating to the activities of other Federal agencies in this area. During 1972 these activities included the publication of four editions of the *Consumer Product Information Index* which have been received by over 15 million consumers. This index includes much information of use to older consumers. These activities also included the

completion on pilot study by the U.S. Army Natick Laboratories of methods for translating technical documents which the Federal Government uses in its purchasing programs into information useful to consumers. On another product information front, the General Services Administration, the largest non-military Governmental purchaser of consumer products, published a listing of the products which it buys that are the same as brand name consumer products.

Publications

In the past year, the Office of Consumer Affairs has prepared a new publication to benefit the older consumer. *Forming Consumer Organizations* is a guide for consumers who wish to establish a permanent voluntary consumer organization in their neighborhood or town to promote the interests and needs of consumers on a local basis.

Also, in the past year, the Office has continued to distribute several publications of benefit to the older consumer, which were prepared in the previous year.

Consumer Education Bibliography.—The updated and revised bibliography lists articles and other information specifically applicable to the elderly on such topics as frauds and consumer protection, health and safety, retirement planning and budgeting for retired couples. The bibliography has been distributed nationally to libraries and those concerned with education, and to delegates attending the White House Conference on Aging.

Consumer News.—This twice-monthly newsletter contains up-to-the-minute consumer news from the Federal Government. Many of the articles have a direct bearing on the elderly.

Guide to Federal Consumer Services.—This booklet lists the consumer services in 34 major Federal departments and agencies and advises consumers on how to avail themselves of these services. It includes information on Social Security programs, the prevention of consumer fraud, and available recreation areas, three subjects of particular interest to older citizens.

Speak Up Series.—These three popular booklets have been translated into Spanish to assist elderly Spanish-speaking consumers when buying a car, when signing a contract, and when approached by door-to-door salesmen.

11 Ways To Reduce Energy Consumption and Increase Comfort in Household Cooling.—Published in conjunction with the National Bureau of Standards, this companion piece to *7 Ways To Reduce Fuel Consumption in Household Heating* tells consumers how to reduce their costs in keeping cool.

Individuals may receive single copies without charge of any of the above publications in which they are interested by writing to the Office of Consumer Affairs.

Consumer News is available for $2 for a year's subscription. (Subscription is available directly from Consumer Product Information, Public Documents Distribution Center, Pueblo, Colorado 81009.) Delegates to the White House Conference on Aging received complimentary subscriptions to *Consumer News* for 1972.

The Office of Consumer Affairs also distributed "Dear Consumer" which is a weekly newspaper column by Virginia Knauer, Special Assistant to the President, and Director, White House Office of Consumer Affairs. "Dear Consumer" is distributed to about 5,000 nondaily and daily (under 25,000 circulation) newspapers. Many topics have been directed to older Americans: how to select a nursing home, nutrition for the elderly, mail-order insurance, problems of interstate land sales, household safety, to name a few.

In addition to its own publications, the Office of Consumer Affairs has worked in an advisory capacity with the Office of Interstate Land Sales at the Department of Housing and Urban Development to improve that Office's publications. Particular concern was devoted to making the information about interstate land laws easy for the elderly to read and understand.

Public Affairs

As part of the "Shop Harder" campaign to help consumers with their food budgets in the face of rising prices, Mrs. Knauer wrote a series of eight articles on food shopping which were sent to food editors across the country. These articles, which have been widely used either in full or in the form of a UPI summary, contain suggestions for saving money on food purchases. This information is helpful to the aging as well as to others who have limited food budgets.

Mrs. Knauer has also continued to press, in speeches to the food industry, for expansion of such consumer shopping aids as unit pricing, open dating and nutritional labeling and advertising. These speeches have advocated industry acceptance of government regulation that would require giving consumers more information on the food they buy, such as regulations requiring percentage labeling of diluted fruit juice drinks and bacon packaging that makes most of the first slice visible.

In a recent speech to the National Association of Chain Drug Stores, Mrs. Knauer urged drug stores to make prescription drug price information more readily available to consumers through posting or advertising prices, by telling consumers that price information is available and by answering consumers' telephone inquiries about prices.

In other speeches directed to elderly consumers, Mrs. Knauer has warned against vacation or retirement land sale schemes that misrepresent the land and facilities offered or the investment value of a property and encouraged victims of such schemes to testify at the hearings on interstate land sales held by HUD. She has also given publicity to the pitfalls multi-level distributorships create for the consumer, and is currently working on obtaining information on one particular scheme that makes a special pitch to retired persons.

Because older people on limited incomes are among those who buy mobile homes, OCA efforts to obtain improvements in the mobile home industry are of benefit to the elderly. In this area, Mrs. Knauer has urged industry support of state regulation, and has called for new initiatives to protect consumers from mobile homes that are "dumped" in a state without regulation because they do not meet standards of those states that do regulate the industry.

ITEM 22. VETERANS ADMINISTRATION

FEBRUARY 15, 1973.

DEAR SENATOR CHURCH: In response to your request of December 15, 1972, I am pleased to forward the enclosed report on the Veterans Administration activities relating to developments in aging for the year 1972.

As you know, this Agency has long had an especial interest in the aging veteran. This interest and the Agency's related activities were recognized by the President in appointing me last August to the Domestic Council and the Council's Subcommittee on Aging. This appointment was at least partially in recognition of the fact that more than one-third of America's 29 million veterans have reached or are approaching the age range of "older citizens," including more than two million who are now 65 or older.

As evidence of our role, you will note that more than 1.7 million persons, age 65 and over, are drawing compensation or pension from the Veterans Administration. Also veterans in this age group may be admitted to VA hospitals without the need to certify that they are unable to pay for the cost of such care.

VA physicians are now engaged in studies of the aging which hopefully will enable us to predict what persons are likely to develop certain diseases and enable us to advise them when preventive measures should be taken. They are finding that much of what has been regarded as "senility" in older persons is treatable mental illness that can be improved with greater involvement by the patients in daily living activities.

The effort being made by your committee to help older Americans is highly commendable, and I hope that our report will be useful for your purpose.

Sincerely,

DONALD E. JOHNSON,
Administrator.

[Enclosure]

VA ACTIVITIES AFFECTING OLDER VETERANS IN 1972, DEPARTMENT OF MEDICINE AND SURGERY

1. VA HOSPITALIZATION AND OUTPATIENT CARE

The Veterans Administration has continued to intensify its care and treatment of aging veterans. Particularly, the agency has sought to intensify its efforts to seek alternatives to hospitalization for the aged ill, where appropriate, but in so doing it has recognized that there often can be no substitute. The percentage

of veterans aged 65 or over who were in VA hospitals on October 20, 1971, climbed to 24.9%, up from last year's 23.7%. This represented a total of 20,202 patients. In addition 19% of all hospital discharges in 1972 were over 65 years of age. But there was corresponding increase in the number of outpatient visits made by older veterans as well. The 1,179,000 visits made by older veterans constituted 13% of all outpatient visits (contrasted with last year's 11%). It must be borne in mind that outpatient treatment offers the first and frequently the most desirable alternative to institutionalization.

2. Extended Care Service

Within the Department of Medicine and Surgery, the Extended Care Service provides a system of facilities to care for a spectrum of patient needs that go beyond inpatient hospital care and thereby serve to provide comprehensive long-term care. While these facilities of course are available to serve all veteran patients requiring such care, they are of particular importance for the aging veterans, since those who are 65 and over make up over one-half of the entire group receiving these services.

Specifically, the Extended Care Service includes:

(1) Skilled Nursing Home Care, for those who no longer require close medical supervision, but whose disabilities are such that they still require skilled nursing care;

(2) Domiciliary Care, for veterans who are disabled by chronic medical or psychiatric disease, but are nevertheless capable of performing the activities of daily living; and

(3) 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 1972, Extended Care Service operated approximately 6,000 nursing care beds and 12,000 domiciliary 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 1972 state facilities had an average veteran census of 5,969 in domiciliaries, 3,335 in nursing home care units, and 1,060 in hospitals.

In addition, skilled nursing homes in the community provided for an average of 3,990 per day under contracts with the VA. In the Hospital-Based Home Care program, six hospitals cared for an average total of 30 patients. In FY 1973 the average daily total is expected to be 158, as the program expands to include ten additional hospitals.

The aim of the Extended Care Service, throughout all these programs, has been to prevent further physical and spiritual deterioration by encouraging the patient to make maximum use of his remaining facilities. Whenever possible, alternatives to institutionalization were sought, and where these could not be effectively utilized, the fact that a spectrum of care was available made it possible to provide such care at the lowest level of institutionalization consistent with the patient's total needs. In all instances, the aim was to provide an appropriate level of care, and neither undertreat nor overtreat.

3. Medical Service

The Medical Service is responsible for the health care of approximately 10,000 "Intermediate" type patients, all of whom have long-term illnesses which require daily medical attention.

In order to offer optimal care to this group of patients, the Medical Service studies methods of assessing their health care needs so as to prescribe therapeutic programs of maximum effectiveness. In addition, plans are formulated to develop specific programs which emphasize rehabilitation of patients with chronic diseases of the cardiovascular, pulmonary, gastrointestinal, and musculoskeletal systems.

Specific studies will be directed towards improving the organization of health care delivery to long-term medical patients. Areas being explored include the maximal use of allied health personnel as physician expanders, and specific encouragement of patient participation in their own care.

4. Mental Health and Behavioral Sciences Service

In past years the activities of the Veterans Administration relating to mental health programs for aging veterans were described in the separate reports of several different professional disciplines. The prevention and treatment of mental

illness and behavior disorders of its veteran patients is one of the largest responsibilities of the Department of Medicine and Surgery. The multifaceted nature of this problem area calls for the integrated involvement of many professional disciplines. Accordingly, a new organizational structure, was implemented in the VA Central Office in February, 1972. The major objectives of this change are to provide a more effective means of planning for mental health services, to develop a mental health treatment capability at every field station, and to insure that an organized program of mental health and psychosocial services is available to all patients receiving health care or entering the health delivery system.

Nowhere is this multidisciplinary approach to mental health more appropriate than in the delivery of these services to the aging and aged veteran. Many of the diseases and disabilities associated with advancing age are manifested as mental health problems or behavioral disorders.

Utilizing knowledge gained through continuing research and evaluation of treatment efforts, a variety of programs for aging veterans were in progress during the past year. Group therapy, counseling, and teaching seminars are conducted in many hospitals and, Day Treatment Centers and other outpatient programs to deal with such problems as successful retirement, improvement of attitudes, and working through other adjustment problems. In some hospitals Reality Orientation programs or special classes are conducted to assist in the improvement of memory and orientation, problems common in the aged. In addition, environmental guides are provided so that those disabled by age can get around in the psychiatric hospital environment or other sheltered living situations. Principles derived from research on the learning process are being applied to assist aging veteran patients. Class-like 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 psychologists 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. This is of major importance in reducing the need for personnel to provide close supervision of all activities.

Specific research is being conducted with drugs which purport to improve memory functions. However, one of the long standing needs of the VA as well as the medical community at large has been a comprehensive and scientific assessment of the effectiveness of a wide variety of chemotherapeutic agents in patients suffering from chronic brain syndrome, a frequent diagnosis in the elderly. To meet this need investigators in the Central Neuropsychiatric Laboratory at the VA Hospital, Perry Point, Maryland conducted a special study. The result was a VA Information Bulletin entitled "Chronic Brain Syndrome, A Review of the Therapeutic Literature with Special Emphasis on Chemotherapy." The requests for copies of this document has been phenomenal which verifies the dearth of information presently existing in this area and the need for more information. The VA hopes to utilize the information gained in its review as a basis for generating cooperative studies on the utilization and effectiveness of chemotherapeutic agents on the mental health and behavior problems of the aging.

At the VA Hospital in Palo Alto, California, a program for retraining of persons with brain damage is proving to be quite successful with many patients. A surprising and very encouraging aspect of this program is that the successes are not limited to the younger patients. Since brain damage is a frequent occurrence in the older population, these findings are very significant.

More and more, it is being recognized that death is not an exclusive eventuality of old age but a basic condition of human life. Further, there is growing appreciation that we must grapple with the meaning of death for the individual if we are to expand our understanding of behavior and life's activities. Additionally, the whole area of attitudes toward dying and death is becoming increasingly relevant because of advances in medicine (hemodialysis, organ transplantation, etc.) bringing in their wake decrease in infant mortality, increased ability to prolong life, and an allied shift in the nature of illness from the communicable diseases (tuberculosis, pneumonia) to more degenerative types associated with aging (heart disease,

cancer, stroke). There is also increasing awareness that such self-destructive and antisocial behaviors as alcoholism, drug abuse, suicidal attempt, and violent conduct have links to overt or latent meanings which death has for the person. An investigator at the VA Outpatient Clinic at Los Angeles has been pioneering and stimulating a resurgence both of research and popular interest concerning the topic. The findings emerging from his work are contributing to more meaningful understanding and treatment of seriously ill and terminally ill patients, indeed to all persons facing the prospect of death in the near future, toward a recasting of the educational training offered in medical, nursing, social work, and seminary schools concerning treatment and care of the dying, the pertinence of personal attitudes about dying and death on the part of professional people to the treatment and care of patients, expanded awareness of the role of grief expression and mourning for the bereaved family, and the possible relevance of attitudes toward death for other social issues.

In summary, the VA continues to explore, develop and evaluate new concepts and ideas related to the delivery of improved mental health services to aging veterans.

5. Social Work Service

Social Work Service, in full support of the VA health care mission, offers individualized services to veterans and their families to achieve and sustain maximum functioning levels within limits of disability and infirmities of aging. Program emphasis is upon using or mobilizing the strengths and assets of the veterans to resolve or ameliorate social, economic, personal, interpersonal, familial, and housing problems of varying degrees and scope.

Services are provided along the continuum of care spanning pre-bed care through hospitalization, discharge and post-hospital care. Selective use of both VA and community resources encompass meals on wheels for aged whose nutritional needs would otherwise not be met; sheltered workshops offering part-time employment, supportive counseling around such issues as retirement, loss of a loved one, development of avocational interests and for the more chronically disabled, placement in suitable living arrangements when independent living is no longer medically and socially feasible.

For FY '72, 17,539 veterans in VA general hospitals were assisted by Social Work Service to secure a change in their living situation by entering personal care homes, nursing homes, domiciliaries, and state soldier's homes. Of the 17,539 veterans, 3,220 were in age range of 50–59; 3,373 were in age range 60–69; and 8,915 were in age range of 70 and over, making a total of 15,508 veterans who were age 50 and over.

Those veterans placed in other than their own homes from VA psychiatric hospitals totaled 7,355 for FY '72. Of this total 1,891 veterans were age 60 and over.

VA via health team inspections, affirms the adequacy and suitability of community homes prior to placement efforts on behalf of veterans. Social Work Service carries major responsibility for continued provision of supportive services to these veterans as needed. Veterans returning to their own homes in isolated areas or those veterans who live alone are contacted by phone at specified times under a new program getting underway called Televoice. If the veteran doesn't answer, help is sent to the home to determine what has happened.

6. Rehabilitative Medicine Service

The Reality Orientation for the Rehabilitation of the Confused Disoriented Elderly Person is a therapeutic program at the Veterans Administration Hospital, Tuscaloosa, Alabama. It emphasizes simple time, place, and person reorientation.

The program has developed training aids which are used to teach others about the care of the confused. In the past three years, the VA has developed ten video tapes and one 16-millimeter film entitled "Return to Reality", for the use of all institutions desiring them for the training of their staffs.

The program in Reality Orientation at Tuscaloosa Veterans Administration Hospital has grown from an Alabama Regional Medical Program project to a national training program meeting the needs of persons in a variety of occupational settings. There were 198 persons trained during a recent 12 month period, including registered nurses (34%), licensed practical nurses (5%), social workers (4%), nursing assistants (19%), volunteers (26%), and nursing home administrators (12%).

Over the past three years, the number attending these training sessions totalled 680 persons, 541 of whom were from the multidisciplinary health care professions and 139 from such facilities as schools of nursing, state welfare agencies, and nursing home organizations. These trainees were from 283 direct care facilities.

A follow-up review conducted to discover the results of the training program indicates that the training resulted in formal Reality Orientation Programs being established in 82 direct-care facilities across the continent, including programs in 22 states and one Canadian province. An additional 15 nondirect patient-care agencies, located in 11 states, have also reported being engaged in some Reality Orientation involvement.

The effectiveness of the Reality Orientation Training Program was also measured in a study on changing attitudes toward the elderly among trainees after their attendance at the training sessions. This study is covered in an article entitled "Influence of a Reality Orientation Training Program on the Attitudes of Trainees Toward the Elderly" by Beverly Smith and Dr. Harry Barker, published in the *Gerontologist* of Autumn 1972.

The effectiveness of the Reality Orientation technique of patient progress was also reviewed by the training program staff in 1971. This study was based on records of 125 patients at the Tuscaloosa VA Hospital who participated in the Reality Orientation Program. The results of this study are reported in an unpublished paper entitled "Reality Orientation at the Veterans Administration Hospital in Tuscaloosa, Alabama: A Historical Study of the Patient Progress." The study revealed that two-thirds of the population remained at the same level of functioning as recorded at hospital admissions, while one-third actually improved in the level of functioning. Only one patient regressed.

The three- to five-day Reality Orientation Training Program sessions have been approved by seven states for nursing home administrators' licensing. Other states are granting credit for nursing home administrators for specific Reality Orientation workshops held within the state.

7. Dietetic Service

Food habits of the aged are firmly established. Therefore, menus are adapted to meet the nutritional requirements of older veterans and their special eating problems while catering to their food preferences. For example, in the VA nursing home care units where a large percentage of patients are elderly, food is served at tables in a dining area within the unit. Food service in close proximity to these patients allows patients' preferences for certain foods and size of portions to be considered. This effort to respect the individuality of the aged motivates them to eat better, thus satisfying both their physical and psychosocial needs.

Edentulous patients and those wearing dentures require that special attention be given to size and texture of food pieces. Whenever possible, food is kept whole rather than ground or chopped to make the menu item more appetizing in appearance. Also, cooked fruits and vegetables are substituted for raw ones when necessary.

Physical limitations as paralysis, feebleness and poor eyesight frequently impede the aged from feeding themselves. Veterans are instructed in the use of eating aids to provide them with a more enjoyable mealtime. Supplemental heat often is provided for dinner plates used in service to slow eaters in order to maintain food at an acceptable and proper temperature.

Dietitians participate in planning for patients' discharge. The geriatric veteran who lives alone is subject to serious nutritional problems. Many do not know how to prepare meals, and those who do know how are not motivated to cook for themselves. Hence, the aged veteran may suffer nutritional deficiencies from undereating or poor eating habits. Prior to discharge to his own home, or to a community nursing home or family care residence, veterans are instructed on normal nutrition, food selection, simple food preparation and budgeting. In addition, to insure continuity in their care, veterans are given information on nutritional resources available in their local community. They are cautioned against food faddism, which frequently victimizes both the health and pocketbook of the aged.

Metabolic studies have been conducted on patients with osteoporosis, a disease found among the elderly. Calcium, phosphorus and fluoride balance, the effect of an anabolic agent on human metabolism, and the absorption and retention of calcium using milk as the principal source of calcium were among the various aspects of this research. Plans are underway for the VA Dietetic Service to participate in the development and conduct of nutrition research in geriatrics at the first self-contained nursing home at Bay Pines, Florida.

As a member of the community placement team, the dietitian visited community nursing homes and other community homes such as family care residences and foster homes. The dietitions' responsibilities are to evaluate the adequacy of the veterans' nutritional care and to make recommendations for improvement when indicated.

Dietitians studied the intake of patients in these community homes and provided nutrition education for both patients and home sponsors. Dietitians reviewed the menus used by nursing home sponsors and suggested changes in selection of food, portion sizes, scheduling of meals, and preparation methods to assist patient in maintaining normal weight and to assure a nutritionally adequate intake.

Home sponsors attended classes at VA hospitals to help them learn how to make diet modifications prescribed by the veterans' physician and about other aspects of the patient's nutritional care.

In the Hospital Based Home Care Program, dietitians provided post hospital nutritional care through scheduled visits to the veterans' homes. Caretakers were given assistance in menu planning, food purchasing and food preparation to assure an adequate intake for the patients while adhering to their diet restrictions. Information regarding the nutritional status of these veterans was brought to the attention of other members of the health care team in an effort to treat the total man.

8. Nursing Service

Nursing Service continues to utilize the team approach to planning and providing individualized nursing care for each veteran patient. This concept has proved successful and has been enhanced by collaboration and coordination with other disciplines on the treatment team to assure that all therapeutic activities are directed toward the same goals for the specific veteran.

The written nursing care plan includes an assessment of each veteran's nursing needs and a plan for action which assures maximal attention not only to those needs related to care during the illness, but to health teaching and supportive assistance for the veteran and his family. The focus of activity is on the realization of the individual veteran's potential for independent functioning, the maintenance of this level and the maintenance of wellness. This plan is developed for the patient in all VA care settings.

The concepts of reality orientation, remotivation, resocialization, and therapeutic recreation are integrated into daily programs involved with care for the aged veteran. Behavior modification is used for selected individuals. Reality orientation in some long term care settings has been adapted to include reorientation to functioning in the contemporary social and social physical environment. Trips to laundromats, dry cleaning establishments, department stores, public libraries, entertainment areas, restaurants, railroad stations, airports, are not only diversional, adding to the quality of life, but also motivate further improvements in Activities of Daily Living (Personal Hygiene, Grooming) and bridge the gap between institutional and community living.

At this time, the patient and his family (where one is available) are active participants in planning his care in many settings. Nursing Service in discharge planning, teaches the patient, his family, or other health worker including non-VA nurses to care for the patient in his home or other setting. When, medically indicated, the Nursing Service provides for follow-up visits to the home through referral to community nursing agencies and orients community health agency nurses or the community nursing home staff to the care of a specific patient. VA nurses also participate in surveys of nursing homes and make follow-up visits to these homes to assure satisfactory adjustment of the veteran to the specific facility.

Nursing Service, the service which is present every day, every hour, believes it has a professional commitment to maintain a service and an environment in which the individual can maintain a satisfying self-image by achieving his optimum level of independent functioning and by participating in activities which permit feelings of achievement/accomplishment, responsibility, and worth as a person, a member of the family unit, and a member of the community. The Service's objectives for the future are to establish a demonstration center for the care of the aged with long term illness and to explore the contribution that a nurse, in an expanded role, can make to impoving care for the aged, in several settings.

9. Voluntary Service

The White House Conference on Aging listed as one of the rights of the aging citizen, the right to be useful. It also listed as obligations of the aging person, to

seek and develop potential avenues of service in the years after retirement and to make available the benefits of his experience and knowledge.

The VA Voluntary Service program of citizen volunteer participation in the care and treatment of veteran patients provides the elderly citizen the opportunity to be useful and to use his skills and talents in service to his fellow man. Elderly volunteers in this program are making significant contributions of service to a cause that gives them a sense of achievement, prestige, stature and recognition. They represent the backbone of the VA Voluntary Service program and are eagerly sought by VA hospitals. They have proven that they are capable of learning new tasks and are available during the day when the need is the greatest.

In addition to providing supplemental assistance to staff in the multiple services in the hospital they also serve in their respective communities helping patients discharged from the hospital with their needs and in making successful adjustments to home and community.

In the VA the elderly volunteer is recognized as a full fledged member of the hospital team and his services are considered indispensable in the care and treatment of veteran patients. These older volunteers may no longer be useful in the commercial world but they are needed and desired in the VA Voluntary Service program which helps them maintain meaning and purposes in their lives. Voluntary Service is helping them make their later years a period of continued growth and development.

The Veterans Administration will continue and seek to expand the use of such voluntary service programs during the coming year.

10. Research Service

The VA medical research program as an adjunct to the patient care activities, seeks to extend the clinical capacities of the medical staff in the diagnosis and treatment of diseases affecting the aging veteran population, such as mental illness, heart disease, cancer, cerebral vascular disease, and other acute and chronic disabilities. A few examples of the research in aging sponsored by the VA follow:

1. According to mortality statistics almost two thirds of all deaths currently are traceable to arteriosclerosis. At the Albuquerque VA Hospital, investigators are attempting to develop a radioisotope which can be injected into the artery at the wrist to detect early in the teens and twenties those persons most likely to suffer coronary attacks and strokes in later life. They have already accomplished this purpose in tests with laboratory animals, using an impure, fat-detecting radio-dye. A pure radio-dye has been synethesized for use in humans, but still has to be approved for such use after further testing with laboratory animals. The test would not only indicate who should employ preventive measures to avoid strokes and heart attacks, but would measure the effect of such preventive measures as diets, exercise and drugs.

2. A study of the effect of low-dose X-irradiation on atherogenesis at the Albany VA Hospital has demonstrated that an immune injury can accelerate the rate and severity of dietary cholesterol-induced atherosclerosis. This type of injury may have clinical significance. At present the investigators are comparing the incidence of arteriosclerotic heart disease in individuals with and without demonstrable immune complexes in serum. This laboratory is also studying the possible regression of various stages of the diet-induced atherosclerosis after removal of the incitant. If such regression occurs, it is planned to study its mechanism and the possible effect of drugs involved in cholesterol and arterial wall metabolism. In the last year, using X-irradiation and a severe atherogenic diet, they were able to produce severe atherosclerosis in the pig and myocardial infarction (heart attack) in 70% of the animals. This is the first time that infarction of the heart has been produced experimentally in such high incidence. Sudden death also occurred in many of these animals. Thus there is here a model which closely simulates the human disease.

3. Research at the Wadsworth (Los Angeles) VA Hospital has been concerned for several years with factors which influence the development of atherosclerosis. One of the characteristic features of atherosclerosis is the accumulation of fat deposits, referred to as plaques or atheromata, at focal points in the arterial wall. In the event that these plaques are formed in the coronary arteries, heart attacks may ensue. The origin and the disposition of cholesterol ester from the arterial wall has been the focus of study. Plasma has been regarded as a source of arterial cholesterol. The extent of accumulation of cholesterol ester in the artery has been correlated with its plasma concentration. Increased formation of cholesterol ester

within the plasma of rabbits maintained on a high cholesterol diet as opposed to a normal diet was considered. Results from these experiments indicate no increase in the activity of the enzyme responsible for the esterification of cholesterol with fatty acid derived from lecithin in plasma. Dual origin of cholesterol ester in atherosclerotic aorta was indicated; at least 13% of the cholesterol ester of the diseased arterial wall was synthesized at that location. Further studies also indicated that activity of the esterifying enzyme in the atherosclerotic aorta was much greater than that in the normal aorta.

The conclusion drawn from these experiments is that the greater rate of formation of cholesterol ester in atherosclerotic aorta as compared to normal aorta could be due to the following in diseased tissue: more of the cholesterol esterifying enzyme; higher concentration of unesterified cholesterol; easier accessibility of fatty acid to the cholesterol esterifying enzyme.

4. Studies carried out at the Hines (Illinois) VA Hospital have shown that female patients with osteoporosis absorb less calcium from a high calcium intake than patients without osteoporosis. Very few data are available for male patients with osteoporosis. In view of the observation made at this hospital that a large number of relatively young, fully ambulatory male patients with chronic alcoholism have demonstrable and symptomatic osteoporosis, calcium absorption studies and calcium balances were determined in male patients with osteoporosis. During low calcium intake, the absorption of Ca and the slightly negative calcium balances of these patients were similar to those observed in patients without osteoporosis. However, on a high calcium intake, the calcium balances became only slightly positive or remained negative despite the marked increase in calcium intake. On performing the calcium tolerance test, the retention of intravenously infused calcium was lower than in normals, an observation which is similar to that made in female patients with osteoporosis. The studies have shown that the low absorption of calcium from the intestine during a high calcium intake is not characteristic of female patients with osteoporosis, but that is is found in male patients with osteoporosis. These studies have also indicated that the amount of calcium needed to attain a positive calcium balance is greater in patients with osteoporosis that in patients who do not have osteoporosis.

5. The underlying defect(s) of the diabetic syndrome is the subject of research at the Seattle VA Hospital. The work so far indicates accelerated and premature aging of the diabetic's capillary bed. This notion fits well with the recent discovery that in vitro the cells from diabetics and prediabetics have shortened longevity and that they are vulnerable to manipulations. These concepts suggest that the genetic defect of diabetics, whatever its nature, is located in the make-up of all diabetic cells and finds expression not only in "microangiopathy" but also in the "premature aging" of the arterial tree in form of arteriosclerosis and perhaps in the failure of beta cells which produce insulin in the pancreas. The questions to be answered by this research are concerned with the nature of the defect which is responsible for the aberrant behavior of diabetic cells in vitro.

6. A computer program with a sufficient number of cases programmed into the computer's memory center in a manner which permits the clinician to take advantage of the computer's instant recall after relating to the problem at hand by a conversational approach has been devised by investigators at the West Haven VA Hospital. For example, a "base population" of 678 previously-treated patients with primary cancer of the lung was collected and classified in an arrangement which enables the clinician to increase or decrease the details of resemblance to his patient's illness. Data on each of the 678 patients is stored in the computer's memory with values for 137 properties in demographic, clinical and other details of his initial state and his subsequent course. There are an additional 13 summary variables: age, sex, smoking, clinical stage, anatomic stage, lateralization of tumor, microscopic type, co-morbidity, presence of chronic cough. bloody pleural fluid, bronchoscopic mass, contrasurgical indication, and duration of pretherapeutic symptoms. The computer responds to common language so the clinician may add or subtract details of similarity to his patient until he has a group large enough to be significant and enough like his patient to make the prognosis relative.

7. An individual's biological, structural and behavioral ages may differ from his chronological age at any given time. Description, correlation of the multifaceted nature of aging, and prediction are the major three aims of the Normative Aging Study at Boston's VA Outpatient Clinic. The invesitgators expect to determine which diseases normally accompany the aging process and to understand better the natural history and development of chronic diseases. The multiple regression of aging accounts for six functional ages: biochemical, auditory, anthropometric, ability, personality and social ages. With sufficient data gathered over a long

period, physicians will be able to predict aging changes in individuals, such as when a person will need bifocals to correct failing sight, or when another must control his diet, exercise, or smoking in order to prevent heart disease. The study of 2,032 healthy World War II veterans has been ongoing since 1963. Veterans who remain healthy will provide insight on disease prevention, health maintenance and longevity. Prediction of aging changes, based on data gathered over a long period, is expected to be the most fruitful of the three main aims of this research program.

ACTIVITIES AFFECTING OLDER VETERANS IN 1972, DEPARTMENT OF VETERANS BENEFITS

1. Guardianship Service

In 1972, the Guardianship program completed the first full year of implementation of regulatory changes affecting the marginally functioning individual—the person on the borderline between competency and incompetency. The typical situation of many marginal VA beneficiaries is one in which there is little or no accumulated estate, and the only income is VA benefits and perhaps Social Security. Most, if not all, of the funds are necessary just to provide food, clothing, and shelter. When the beneficiary has some understanding of his financial situation and has a friend or relative who helps him, or his living arrangement is such that someone is around to see that he applies his benefits to his needs, a fiduciary may not be necessary. Yet, the beneficiary may not be sufficiently capable of handling his affairs to be rated competent by the VA's adjudicating activity.

Agency regulations previously required that benefit payments be made through a fiduciary when the beneficiary was rated incompetent. Under the revised regulations, payments may be made directly to the beneficiary provided he is not under court-adjudicated legal disability. When payment is made directly to an incompetent beneficiary, periodic personal contacts will be made to evaluate his status. If the beneficiary deteriorates to the point where a fiduciary is necessary, one will be obtained. On the other hand, if the beneficiary improves to the point where a competency rating seems to be in order, evidence will be submitted to the agency's adjudicating activity for that determination.

This arrangement, supervised direct payment, provides the degree of assistance the individual beneficiary requires and still leaves him a free and unencumbered member of society.

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 1,729,486 persons age 65 and older. This total is broken down to 865,660 veterans, 692,896 widows, 127,843 mothers, and 43,087 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 to 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.

ITEM 23. REPORT OF THE POST-CONFERENCE BOARD, WHITE HOUSE CONFERENCE ON AGING, ARTHUR FLEMMING, CHAIRMAN

I. The Conference Period: Mandate From the Delegates

The principal tasks of the Post Conference staff during 1972 have been the coordination of the Final Report of the 1971 White House Conference on Aging, assisting in the development of the Administration's response to the recommenda-

tions of the delegates, and providing staff assistance for the study panels that have worked on the preparation of a Report of the Post Conference Board on the implementation of Conference recommendations.

In February, 1973 the Final Report of the Conference was published in two volumes and covers the history and proceedings of the Conference, along with the recommendations from the Conference.

Following the White House Conference on Aging, the Post Conference staff communicated to officials of the various Departments and Agencies those recommendations of the Conference which fell within the domain of the programs or resources which they administered. These efforts were designed to elicit the policy positions of the federal departments and agencies with respect to the recommendations of the Delegates. The collection of the responses which were made to these recommendations will be available at the end of April 1973 and will be entitled: "Administration Response to the Recommendations of the 1971 White House Conference on Aging."

In his speech at the White House Conference on Aging, the President requested that a Post Conference Board be created to follow up on the progress made toward implementation of the Conference recommendations. Accordingly, a Board of one hundred and five members was designated. Membership includes former Delegates, members of the study groups who participated in the pre-planning of the Conference, expert consultants from the field of aging and representatives from private organizations representing the elderly. Of the total membership, twenty percent are members of racial and ethnic minorities.

For purposes of carrying out their assignment of analyzing the extent and nature of the action taken in response to the Conference recommendations in May 1972, the members of the Post Conference Board of the WHCoA created nine study panels. Each study panel has concerned itself with a different subject area covered by the Sections and Special Concerns Sessions of the Conference. Membership on the panels has included Board members and professional experts in the fields under study.

The Board further authorized the Post Conference staff to solicit information from the national organizations and the various levels of government (including the local, state, federal and legislative units of government) regarding the progress they had made toward implementing Conference recommendations. At the time of this writing, each study panel is in the process of reviewing and commenting on the material that was submitted.

Based on the reports of the study panels, the Post Conference Board will make a report to the President. Included in the report will be an identification of actions or failure to act in carrying out the recommendations of the Delegates to the White House Conference, and recommendations of additional steps that can and should be taken.

II. Interagency Communications

The Post Conference staff, building upon the interagency cooperation and communication networks that had been established prior to the Conference, was able to respond, on an ad hoc basis, to several special situations which had far-reaching implications for older people.

Tropical Storm Agnes had a particularly severe effect on the older people living in the ravaged areas. The Conference staff took the lead in assembling representatives of Departments with programs for the aged to examine the extent to which the special aging resources throughout the federal government could be marshalled to enhance the benefits of the disaster relief program for older people.

An exchange of information took place between local, State, federal regional and federal headquarters personnel as to the special needs of the aged flood victims, and the ability of existing programs to assist in addressing these needs.

Another opportunity to provide interagency leadership came with Project FIND. Because the White House Conference on Aging Delegates strongly endorsed "action programs to rehabilitate the malnourished aged," the Post Conference staff provided support to the Domestic Council Cabinet Committee on Aging in overseeing the development and implementation of this program. In this connection, Conference staff continued their role as a coordinator of the federal agencies which played a major role in Project FIND—the Department of Agriculture, the Department of HEW, ACTION and the Office of Economic Opportunity. In this instance the communications and coordination function extended beyond the immediate scope of the federal government and additionally

involved State and county welfare offices, State agencies on aging, and a number of private organizations including the American Red Cross which organized volunteers to make personal contact with older people. This new program was launched on August 3, 1972.

Project FIND was a short-term outreach campaign aimed at locating those older people who are faced with the threat of malnutrition as a result of their inability to afford necessary food items. The strategy was two-fold—communicating to older people the benefits available through federally funded food assistance programs, and, where possible, assisting them in making applications for such benefits.

The Conference also provided staff support in the collection and review of fiscal information provided by the federal departments and agencies in response to the President's request to coordinate federal programs for the aged.

III. Extra Government Activities

Following the Conference, appeals from older people poured into the Conference offices for an aggressive approach to be taken toward improving life for older people in this country. The need for someone to fill the role of advocate became evident.

On several occasions, Conference staff contributed to filling this need.

The Conference was instrumental in bringing to the attention of the Postal Service the particular needs of older persons. The staff also cooperated with the Cost of Living Council in mounting the "Rent Watch." (The "Rent Watch" was initiated to assure that the 20% increase in Social Security which was signed into law on July 1, would not be siphoned off through unfair or unjustified rent increases.)

With the passage of the State and Local Fiscal Assistance Act, Conference officials joined representatives from the National Organizations with programs for older people in identifying and communicating the implications of this new program for older persons.

IV. Other

The variety of other activities of the Post Conference staff included overseeing the development of several Conference related publications. *Toward a National Policy on Aging:* Final Report Volumes I and II was published in February 1973. These two volumes include the complete proceedings of the Conference along with background information on the history of the Conference.

Another major publication of the Conference which is related to the previously mentioned Report of the Post Conference Board is a detailed discussion of the Administration's position with respect to the policies reflected in the recommendations of the Delegates. This response from the Administration will be made available at the end of April.

To show the extent to which Delegates shared common opinions about basic and overriding issues and about the methods to be used in resolving them, a collection of 23 pamphlets entitled "Recommended for Action" was released shortly after the Conference. The individual pamphlets were organized to present each recommendation of a Section together with the recommendations closely related to it proposed by other Conference groups.

To encourage continuing nationwide consideration of the Delegates' recommendations, a series of press conferences were held for purposes of releasing these pamphlets and receiving questions about them.

Appendix 2

SURVEY OF MODEL CITIES AGING PROGRAMS [1]

(Detailed Findings by the National Council on the Aging)

FEBRUARY 1973

INTRODUCTION

The National Council on the Aging conducted a survey of aging programs within Model Cities Neighborhoods operated by Model Cities Delegate Agencies. This survey, carried out in February and March of 1973, contained questions regarding type of delegate agency, services delivered, total funding and primary funding source as well as future plans for continuation of services without Model Cities financial support.

All Model Cities CDA's [2] were queried and the data was supplied by officers of the CDA and/or the delegate agency conducting the aging programs. The future of many Model Cities CDA's as well as delegate agencies had not been decided or, at best, there were tentative plans for continuation. As the survey reveals, of the 132 Model Cities with aging programs and services, 102 have plans for continuation, 30 are uncertain, and 28 will discontinue operations.

SUMMARY OF SURVEY FINDINGS

132 Model Cities maintain programs serving the elderly population.

Types of agencies maintaining such programs include:	Programs
Senior centers	18
Councils on aging	12
Health organizations [3]	10
CAA's	8
Parks and recreation departments	7
Religious groups	6
Multiservice centers	5
Miscellaneous local groups [4]	92

The 10 most frequently offered services were:

(1) Meals programs;
(2) Transportation service to and from hospitals, shopping areas, etc.;
(3) Recreational activities (games, reading, musicales);
(4) Information and referral services;
(5) Health Care (especially dental and optometric services);
(6) Homemaker services;
(7) Arts and crafts;
(8) Outreach services;
(9) Counseling on legal, medical, etc. problems; and
(10) Education (especially in the area of nutrition).

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[1] See Chapter X, part VI for additional discussion of Model Cities.
[2] A key to this and all other abbreviations will be found following the su mmary of survey findings, below
[3] This category includes hospitals, etc.
[4] This category includes single groups, mainly local who are too numerous to list.

Sources of funding:	
Supplemental funds	$13, 231, 060
HEW	1, 957, 644
Local governments	821, 850
United fund	687, 619
State funds	684, 127
SCOA's	367, 495
Community service projects	349, 350
Title XVI	342, 265
Religious groups	330, 462
Title III	312, 935
CDA's	160, 000
OEO	150, 728
CAA's	139, 000
Federal moneys	73, 954
Title II	43, 825
COG's	27, 500
Health organizations	15, 000
Voluntary groups	2, 000
All other groups	1, 174, 550
Agency plans for the future:	
Continue	102
Uncertain	30
Discontinue	28

KEY TO ABBREVIATIONS

CAA—Community Action Agency
CAP—Community Action Program
CDA—Community Development Agency
COA—Commission on Aging
COG—Council of Governments
DHEW—Department of Health, Education, and Welfare
OEO—Office of Economic Opportunity
SCOA—State Commission on Aging

HUD REGION I

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Bridgeport, Conn.	Mayor's Commission for Senior Citizens, 45 Lyon Terrace, Bridgeport, Conn.	Activity Program, Education (Consumer Education), Information and Referral Service.	Supplemental funds SCOA; DOL; City, $19, 000. No breakdown given.	Yes.	Unidentified.
Hartford, Conn.	Albany Avenue Senior, Center, 362 Albany Ave., Hartford Conn.	Transportation; minibuses; four field workers; crafts; social activities; ceramics; Social Security.	Supplemental funds, $67, 000.	Yes.	The city of Hartford, State Department on Aging, and United Progressive Seniors, Inc.
New Haven, Conn.	Robert T. Wolfe Center, 49 Union Ave., New Haven, Conn.	Recreation and educational activities, Hot Lunch Program, information and referral, Outreach, transportation.	Supplemental funds, $17,475.	Yes.	Unidentified.
New London, Conn.	Elderly Citizens Helping Others, Inc., New London, Conn.	Visiting service, running errands, transportation, and nutrition services.	Supplemental funds, $44,000.	Yes.	Present delegate agency.
Lewiston, Maine.	Lewiston Council for Older People, Lewiston, Maine.	Hot Lunch Program, arts and crafts, trips and classes.	Supplemental funds, $120,000.	Yes.	City of Lewiston.
Portland, Maine.	Bureau of Human Relation Services, 317 Congress St., Portland, Maine.	Meals on Wheels, Homemaker Service, transportation, arts and crafts; games.	Supplemental funds, $150,000.	No.	
Cambridge, Mass.	Cambridge-Summerville Home Care Corporation, Cambridge, Mass.	General Social Services to the Elderly.	Cambridge, $10,000; Summerville, $10,000; State Department of Elder Affairs, $60,000; total $80,000.	Yes.	State of Massachusetts Department of Elder Affairs.

HUD REGION I—Continued

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Fall River, Mass.	Fall River Council on Aging, 1197 Robinson St., Fall River, Mass.	Drop-in centers; information and referral; Senior Aid Program; home visits; transportation.	Supplemental funds, $153,159.	Uncertain.	
Holyoke, Mass.	Holyoke Council on Aging, The War Memorial Building, 310 Appleton St., Holyoke, Mass.	Health Care; Employment Opportunity; information and referral; social activities.	Supplemental funds, $32,000.	Yes.	City and State Commonwealth Service Corporation.
Lowell, Mass.	Lowell Council on Aging, 302 Market St., Lowell, Mass.	Mini-bus service; Outreach; Meals on Wheels; Friendly Visitors; Telephone Reassurance; transportation; Public Escort Service; Hot Lunch Program.	Supplemental funds, $73,000; City of Lowell, $18,750; total, $91,750.	Yes.	City of Lowell.
Lynn, Mass.	Lynn Council on Aging, 65 Union St., Lynn, Mass.	Counseling on the following: recreation; social services; Social Security; housing, income tax; welfare, transportation, health, leisure time activities; funding.	Supplemental funds, $40,000; OEO funds, $25,000; city taxes, $15,000; Title III (OAA), $45,000; total, $125,000.	Yes.	City of Lynn.
New Bedford, Mass.	Multi-Service Center, 157 Acushuet Ave., New Bedford, Mass.	Transportation, psychiatric services, home management; translation and social services.	Supplemental funds, $280,000 approximate.	Yes.	The New Bedford Board of Health Multi-Service.

Boston, Mass.	Council of Elders, Inc., 280 Martin Luther King, Roxbury, Mass.	Nutrition program; Legal Research Program; Homemaker Service; Meals Home Service; Group Work Activities; information and referral and health services.	Model Cities HUD, $230,000; OEO funds, $87,000; HEW funds, $80,000; Massachusetts Department of Welfare, $200,000; Massachusetts Department of Education, $30,000; total, $627,000.	Yes.	State of Massachusetts; State Department of Education; State Department of Welfare; private sources.
Springfield, Mass.	Springfield Model Cities Agency, 736 State St., Springfield, Mass.	Nutrition Program; transportation and recreation activities.	Supplemental funds, $20,000.	Yes.	Local home case.
Worcester, Mass.	Center of Worcester, Inc., 5 Main St., Worcester, Mass.	Outreach; referral and social activities.	Supplemental funds, $28,000.	Yes.	IV–A State public welfare.
Manchester, N.H.	The Neighborhood Information Regional Office, Pine St., Manchester, N.H.	Homemaker Services; transportation; hot meals; leisure activities.	Supplemental funds, $110,000 approximately.	Yes.	City of Manchester.
Pawtucket, R.I.	Blackstone Valley CAP, 150 Main St., Pawtucket, R.I.; Visiting Nurse Service 277 Cottage St., Pawtucket, R.I.; Pawtucket Memorial Hospital, Prospect St., Pawtucket, R.I.; Public Transit Authority, Pawtucket, R.I.	Nutrition; health and transportation.	Supplemental funds, $94,000.	Uncertain.	

HUD REGION I—Continued

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Providence, R.I.	SECAP Social Service, Center, 25 Mystic St., Providence, R.I.	Counseling; referral; educational activities; recreational activities; meals; transportation.	Supplemental funds, $135,471.	Yes.	SECAP.
Mount Pelier, Vt.	Council on Aging, Mount Pelier, Vt.	Social Security information; tax referral; leisure activities; recreation.	Supplemental funds, $10,000.	Uncertain.	
Waterbury, Conn.	P.R.I.D.E., Inc., Waterbury, Conn.	Formerly had a senior citizens' service program and a meals service. Due to the cessation of funding, these services have been temporarily discontinued.	Awaiting word on funding from Model Cities.		

HUD REGION II

East Orange, N.J.	No programs for the elderly.				
Hoboken, N.J.	No information available.				
Jersey City, N.J.	No programs for the elderly.				
Newark, N.J.	Red Cross, 710 High St., North Newark, N.J.	Transportation to and from health services.	Supplemental funds, $46,000.	No.	
Paterson, N.J.	YWCA, 185 Carroll St., Paterson, N.J.	Meals served at facility and delivered.	Supplemental funds, $202,000; YWCA, $50,000; total, $250,000.	Yes.	New Jersey State Office on Aging.
	YMHA, 152 Van Houten St., Paterson, N.J.	Transportation service where there are no buses.	Supplemental funds, $14,000.	No.	

Perth Amboy, N.J.	Family Counseling agency, 255 State St., Perth Amboy, N.J.	Information and referral service.	Supplemental funds, $13,000.	No.	
	Meals on Wheels Corp., 256 Smith St. Perth Amboy, N.J.	Delivery of hot meals.	Supplemental funds, $44,000.	No.	
Plainfield, N.J	Neighborhood House, 644 West 4th St., Plainfield, N.J.	Nutrition program; information and referral physical exams; games.	Supplemental funds, $43,539.	No.	
Trenton, N.J.	Mercer Street Friends Center, Mercer St., Trenton, N.J.	Meals program; Homemaker Service; arts and crafts.	Supplemental funds, $188,445.	Yes.	Mental Health Department; Law Enforcement Planning.
Binghamtom, N.Y.	Pine Haven Senior Citizens Center, 37 Pine St., Binghamton, N.Y.	Meals program; recreational activities.	Supplemental funds, $21,253.	Yes.	Unidentified.
	Broome County Government, County Office Building, Binghamton, N.Y.	Meals; Homemaker Services, transportation; information and referral; crafts; Semi-independent living program.	Supplemental funds, $114, 410.	Yes.	County and Federal funds.
Buffalo, N.Y.	Model Cities Senior Citizens Center, 1490 Jefferson Ave., Buffalo, N.Y.	Meals program; counseling; crafts; health services.	Supplemental funds, $88,000; $174,000 2 years.	Yes.	Unidentified.
	Model Cities Jitney Transportation Project, 576 Jefferson Ave., Buffalo, N.Y.	Free transportation service 7 days a week.	Supplemental funds $770,533, 3 years.	No.	
Cohoes, N.Y	Cohoes Multi-Service Senior Citizen Center, 97 Mohawk St., Cohoes, N.Y.	Employment Service; recreational activities; meals at the center and delivered; field trips.	Supplemental funds, $21,000; Albany Catholic Diocese, $13,000; city, $14,000; United Funds, $2,500; Cohoes Senior Citizens, $1,500; total $52,000.	No. (However, looking for funds.)	

HUD REGION II—Contiuued

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Mount Vernon, N.Y.	City of Mount Vernon Recreation Department, Roosevelt St., Mount Vernon, N.Y.	Counseling; Homemaker Services; financial assistance; recreation; meals; medical assistance.	Supplemental funds, $95,000.	Yes.	City recreation department.
New York, N.Y.	New York City Office on Aging, 250 Broadway, New York, N.Y.	Plan programs for the elderly in Harlem; information and referral.	Supplemental funds, $221,000.	Yes.	New York City Office on the Aging.
Poughkeepsie, N.Y.	No program for the elderly.				
Rochester, N.Y.	Senior Citizens of Model Cities, Inc., 33 Hollister St., Rochester, N.Y.	Advocacy for Social Economics; health and legal services; recreational activities and information and referral.	Supplemental funds, $25,000.	Yes.	Unidentified.
San Juan, P.R.	Department of Community Action, 252 San Jose St., San Juan, P.R.	Services to homebound elderly; Home Health Aid.	Supplemental funds, $209,000 (3 projects).	Yes.	Unidentified.
		Housekeeping, employment.	See above.	Yes.	Unidentified.
		Nutrition programs; recreation and health.	See above.	Yes.	Unidentified.
Syracuse, N.Y.	Syracuse Housing Authority, Bent St., Syracuse, N.Y.	Arts and crafts; gathering dishes and appliances for the elderly.	Syracuse Housing Authority, $2,500.	No.	
	PEACE, Syracuse, Syracuse, N.Y.	Transportation for the elderly.	Supplemental fund, $15,000.	No.	

Wilmington, Del.	Delaware Office of Economic Opportunity, 504 West 19th St., Wilmington, Del.	16 beneficiaries.	Supplemental funds, $8,000.	Yes,	Unidentified,
	Geriatric Services of Delaware, Inc,, 1300 North Broom St., Wilmington, Del.	Meals-on-Wheels; Homemaker Services; counseling and referral.	Supplemental funds, $47,000; Title IV-A, $8,000; total $55,000.	Yes.	Unidentified,
	West Community Center, 8th and Washington Sts., Wilmington, Del.	Nutrition programs and social services.	Supplemental funds, $13,000.	Yes.	Unidentified,
Washington, D.C.	Washington, D.C., Family and Children Services, L Street, N.W., Washington, D.C.	Transportation; meals; information and referral; health services; Homemaker Services; recreational activities.	Supplemental, $234,000.	Yes.	District of Columbia,
Baltimore, Md.	Epsilon Omega, Inc,, 3474 Dolfield Ave., Baltimore, Md.	Day care; education; Outreach; meals program; workshop activities.	Supplemental funds, $300,000,	Yes.	Housing, Community Development, revenue sharing.
Capital Heights, Md.	Prince Georges County, CDA, Capital Heights, Md.	Drop-in centers; meals etc. This group serves not only Model city residents, but elderly throughout the area.	ACTION, $200,000. Varying amounts from non-Federal sharing sources.	Uncertain.	
Erie, Pa.	City of Erie, 404 Municipal Building, Erie, Pa.	Meals program; recreational seryices and educational services.	Supplemental funds, $70,000.	Yes.	Unidentified.
	United Community Services, 110 West 10th St., Erie, Pa.	Provides nutritious meals to the elderly who are unable to do so themselves.	Supplemental funds, $8,000.	Yes.	Unidentified.

HUD REGION III—Continued

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Lancaster, Pa.	No programs relating to the elderly.				
Philadelphia, Pa.	Senior Wheels West Wharton Center, 2914 West Dauphin St. Philadelphia, Pa.; Senior Wheels East Old Kensington Redevelopment Corp., 1313 North 4th St., Philadelphia, Pa.	Mobile units; visiting services; information and referral; group meetings.	Supplemental, $380,000.	Yes.	Department of Public Welfare and Bicentennial Planning group.
Pittsburgh, Pa.	Allegheny County Institution District, Allegheny Building Room 404, Forbes Building, Pittsburgh, Pa.	Social services; recreational activities; senior aide program; information and referral; Meals-On-Wheels.	Supplemental funds, $73,000; Salvation Army and Department of Welfare, $73,000; total, $146,000.	Yes.	Unidentified.
	Hill House Association, Center Ave., Pittsburgh, Pa.	Meals-on-Wheels; recreation; day care; information and referral.	Supplemental funds, $278,000.	No.	
	Transitional Services for Senior Citizens, Inc., Forbes Ave., Pittsburgh, Pa.	Housing; Homemaker Service; Home Repair Service; transportation.	Supplemental funds, $104,000.	No.	
Reading, Pa.	Berks Multi-Service Center, Inc., Reading, Pa.	Counseling; information and referral; Outreach, socialization program.	Supplemental funds, $73,000 ($9,000 for Aging Coordinator); Title IV–A, $220,000; total, $293,000.	Yes.	Foster Grandparents and RSVP.
Scranton, Pa.	Neighborhood Facility Centers, Scranton, Pa.	Drop-in services.	Local, $80,000; State, city, Federal, $900,000; total, $980,000.	Yes.	Unidentified.

Wilkes-Barre, Pa.	Human Service Center Wilkes-Barre Information System, Coordinated Health, Wilkes-Barre, Pa.	Meals; information and referral; a soon-to-be-inaugurated aquatic program for area elderly.	Supplemental funds, $65,000; United Fund, $163,200; welfare department, $45,000; total, $273,200.	Yes.	Unidentified.
Richmond, Va.	Richmond CAP, 1010 East Marshall St., Richmond, Va.	Counseling, information and referral; Meals-on Wheels; transportation.	Supplemental funds, $80,000; State agency on aging, $20,000; total, $100,000.	Yes.	Unidentified.
Norfolk, Va.	Southeastern Virginia Areawide Model Program, 9 Kroger Executive Center New Town Rd., Virginia Beach, Va.	Referral and information; transportation to medical and social services.	Supplemental funds, $41,570.	No.	
		HUD REGION IV			
Huntsville, Ala.	Huntsville Opportunity Program for the Elderly, Huntsville, Ala.	Friendly visiting; crafts; employment assistance.	Supplemental funds, $50,000; Titles I, X, XIV, $160,000; total $210,000,	Yes.	
Tuskegee, Ala.	Senior Citizens Program of Tuskegee, Tuskegee, Ala.	Outreach transportation; recreation.	Supplemental funds, $35,000; Alabama Commission on Aging, $4,000; total, $39,000.	Uncertain.	
Miami, Fla.	Senior Citizens' Law, 4705 NW. 27th Ave., Miami, Fla.	Law services for the elderly.	Model Cities money, $260,000.	Yes.	
Tampa, Fla.	Tampa Metropolitan Development Agency, Tampa, Fla.	Recreation; transportation; referral and counseling.	Model Cities planned variation moneys, $10,835; Title II, $42,835; total, $53,770.		
Alma, Ga.	Community Service Center, 609 Tenth St., Alma, Ga.	Transportation, arts and crafts.	Supplemental funds, $7,500; Title XVI, $8,265; Title III, $5,501; total, $21.266.		

HUD REGION IV—Continued

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Athens, Ga.	Athens Community Council on Aging, 230 South Hull St., Athens, Ga.	Homemaker Services; day care; Meals-On-Wheels.	Supplemental funds, $100,000; Title IV–A; $283,000, United fund, $9,000; total, $392,000.	Uncertain.	United fund; Community Council on Aging.
Atlanta, Ga.	Senior Citizen Services of Metropolitan Atlanta, Glenn Building, 120 Marietta St., Atlanta, Ga.	Social Services; day care; Meals-On-Wheels; health care.	Supplemental funds, $35,000. Unspecified amount from Titles III and XVI.	Uncertain.	Unidentified.
Gainesville, Ga.	Neighborhood Service Center, Parks and Recreation Department, Economic Opportunity, Gainesville, Ga.	Homemaker Service; home health aides; transportation; day care; Meals-On-Wheels; case work.	Supplemental funds, $52,000; Title XVI; $174,000; total, $226,000.	Uncertain.	Health Department; Commission on Aging, and Appalachia.
Savannah, Ga.	Senior Citizen Services of Savannah-Chatham Co. Inc., 905 East Duffy St., Savannah, Ga.	Congregate meals and Meals-On-Wheels.	Supplemental funds, $200,000.	Uncertain.	Unidentified.
Bowling Green, Ky.	Barren River CoA, Bowling Green, Ky.	Meals-On-Wheels; prescription service; transportation service; visiting aides; health aides service.	Supplemental funds, $8,000; Local health authority, $1,500; Kentucky CoA, $28,500; total, $38,000.	Yes.	Barren River CoA.
Covington, Ga.	L. B. Souse Civic Center, Bush St., Covington, Ky.	Meals-On-Wheels; Homemaker Service.	Supplemental funds, $43,000. Unspecified amount from Community Chest and Welfare program.	Uncertain.	Unidentified.

Pikeville, Ky.	Church Women United, Pikeville, Ky.	Home delivered meals.	Volunteer service with some church funding.	Yes.	Church Women United.
Asheville, N.C.	Asheville Parks and Recreation, City Hall, Asheville, N.C.	Meals-On-Wheels; recreation; arts and crafts; information and referral; transportation.	Supplemental funds, $134,052.	Yes.	State agency on Aging.
Charlotte, N.C.	City Demonstration Agency, Charlotte, N.C.	Health education; recreation; arts and crafts; Meals-On-Wheels.	Supplemental funds, $25,000	Yes.	OAA and United Funds.
High Point, N.C.	Guilford County Council on Aging, Community Health Services, 1301 North Elm St., Greensboro, N.C.	Coordinating services.	Supplemental funds, $5,000; Title III OAA, $32,757; Greensboro United Community Service, $5,919; total, $43,676.	No.	
Winston-Salem, N.C.	Experiment in Self-Reliance CAP, 601 North Main St., Winston-Salem, N.C.	Recreation; consumer education; transportation.	Supplemental funds, $11,292.	No.	
	Winston-Salem Housing Authority, 901 Cleveland Ave., Winston-Salem, N.C.	Social services; attendant care; transportation; counseling; information and referral.	Supplemental funds, $17,752.	No.	
Rock Hill, S.C.	Rock Hill Senior Center, Black Street, Rock Hill, S.C.	Referral, employment and housing information.	Supplemental funds, $40,000; United Fund, $7,000; city, $7,000; South Carolina CoA, $7,000; total, $61,000.	Yes.	Catawba Regional Planning District.

HUD REGION IV—Continued

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Rock Hill, S.C.	City Social and Economic Department, City Hall, Winthrop College, Recreation Department, Rock Hill, S.C.	Transportation; social activities; housing referral; cultural enrichment.	Supplemental funds, $225,000.	Uncertain.	Unidentified.
Spartanburg, S.C.	Spartanburg CoA, Spartanburg Department of Social Services, Spartanburg, S.C.	RSVP programs; telephone reassurance and a nutrition program in the making.	Supplemental funds, $3,160; OAA, HEW, RSVP, $11,328; Local in-kind, $6,288; City Department of Social Services, $30,316; total, $51,092.	Uncertain.	City department of social services and Clemson College Extension Service.
Chattanooga, Tenn.	Community Action Agency, Neighborhood Senior Center, Chattanooga, Tenn.	Counseling and referral; recreation and crafts; Meals-On-Wheels; transportation.	Supplemental funds, $128,000.	Yes.	Model City Program.
Cookeville, Tenn.	OEO, Department of Health, Department of Parks and Recreation, Cookeville, Tenn.	Arts and crafts; Meals-On-Wheels; day care; recreation; Senior Vitamin program; education.	Supplemental funds, $15,084. Unspecified amount from Putman Co. Parks and Recreation and SCoA.	Yes.	Unidentified.
Nashville, Tenn.	Gordon Methodist Church, Herman St., Nashville, Tenn.	Home delivered meals.	Supplemental funds, $73,000; State of Tennessee, $5,000; Gordon Methodist Church, $2,000; total $80,000.	Yes.	Unidentified.

	City Department of Parks and Recreation, Nashville, Tenn.	Arts and crafts; recreational activities.	Supplemental funds, $34,000.	Yes.	City of Nashville.
Smithville, Tenn.	De Kalb Senior Citizens, Smithville,	Recreation; transportation.	Supplemental funds, $25,000; State, $4,500; local, $1,800; total, $31,300.	Yes.	RSVP.
		HUD REGION V			
Carbondale, Ill.	Carbondale Senior Citizens Center, 740 North Oakland, Carbondale, Ill.	Meals; recreation; arts and crafts; transportation.	Supplemental funds, $12,000; State funds, $57,000; total $69,000.	Yes.	Unidentified.
Chicago, Ill.	The Mayor's Office For Senior Citizens, 223 North Michigan St., Chicago, Ill.	Information and referral; counseling.	Supplemental funds, $251,000.	No.	
East St. Louis, Ill.	City of East St. Louis, East St. Louis, Ill.	Arts and crafts.	Supplemental funds, $20,513.	No.	
	City Health Department and Metro East Health Services Council, East St. Louis, Ill.	Hot meals program.	Supplemental funds, $70,000.	No.	
Rock Island, Ill.	Rock Island Public Workers, OEO and Model City, City Health Department, Rock Island, Ill.	Transportation; Outreach; Neighborhood Health Center.	Supplemental funds, $380,000.	Yes.	State and County Funds.
Gary, Ind.	Metro Corporation, Inc., Project Loaves and Fishes, 1100 Massachusetts St., Gary, Ind.	Hot Lunch Program Loaves and Fishes Project.	Formerly funded by Model Cities, presently funded by OEO.	No.	

HUD REGION V—Continued

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Indianapolis, Ind.	Late Start CAP, 611 North Park Ave. Near Eastside Community Organization, 2222 East 10th St. Indianapolis Settlement, 502 N. Tremont St., Indianapolis, Ind.	All three agencies offer approximately the same services: meals; social services; recreation.	Foundation funds, $9,000; Foster Grandparents, $165,000; CDA funds, $160,600; SCOA, $25,000; CSP, $150,750; total, $460,350. Near Eastside CSP $138,500, Indiana Settlement CSP $60,000.	Yes.	Unidentified.
South Bend, Ind.	Real Services, 521 West Colfan, South Bend, Ind.	Meals; transportation; recreation; employment.	Supplemental Funds $18,141.	Yes.	Nutrition Plan, State Commission on Aging.
Ann Arbor Mich.	Dental Clinic, 704 Spring St. Transportation Inc. 625 North Main St., Ann Arbor, Mich.	Dental Services and transportation for the elderly. Plan in to the Social Security Office for a Multi-purpose center.	Supplemental funds, $2,000–3,000, allotted for the elderly.	Yes.	
Benton Harbor, Mich.	Citizens Participation, Benton Harbor, Mich.	No program yet but hope for funds shortly.	Not yet available.	Yes.	Citizens participation.
Detroit, Mich.	No program planned as yet.	Several neighborhood centers have some recreational equipment which may be loaned out and occasionally senior groups take advantage of this.			

Flint, Mich.	Flint Board of Education, Flint, Mich.	Trips; friendly visiting; telephone reassurance; Meals-On-Wheels; transportation and Outreach.	Supplemental funds, $175,000; Title III, $60,000; total, $235,000.	Yes.	City of Flint.
Grand Rapids, Mich.	Senior Citizens, Inc., Grandville Ave., Grand Rapids, Mich.	Arts and crafts.	Supplemental funds, $2,000; CAA, $8,000; total, $10,000.	No.	
	Methodist Community Center, Grand Rapids, Mich.	Meals; Outreach; transportation; home health services; phone service.	Supplemental funds, $34,000; Michigan Department of Social Services, $100,000; total, $134,000.	Yes.	City and county.
Highland Park, Mich.	No specific program.				
Lansing, Mich.	Senior Citizens, Inc., Lansing, Mich.	Meals-On-Wheels; recreation; home repairs; employment; transportation; counseling.	Supplemental Funds $77,000; other funds from OEO.	Yes.	Unidentified.
	Lansing Planning Board, Lansing, Mich.	Planning at this time.	Lansing Planning Board, $14,995; Michigan CoA $44,495; total, $59,490.	Uncertain.	Unidentified.
Duluth, Minn.	Miller-Duane Hospital City Library, Duluth, Minn.	Delivered meals; book rentals; talking books.	Supplemental Funds $21,590.	Yes.	Unidentified.
Minneapolis, Minn.	Private non-profit board and donated services from Abbott-Northwestern Hospital.	Meals-On-Wheels; employment; counseling; telephone reassurance; health programs; information and referral; transportation.	Supplemental Funds $227,000.	Uncertain.	Unidentified.
St. Paul, Minn.	Willows Nursing Home, Hallie Q. Brown Ctr., St. Paul, Minn.	Day care; Meals-On-Wheels; recreation; Outreach.	Supplemental Funds, $100,000; HEW and Local Welfare, $200,000; total, $300,000.	Yes.	Unidentified.

HUD REGION V—Continued

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Saginaw, Mich.	Saginaw Senior Citizens Council, Inc , Saginaw, Mich.	Meals program; transportation; information and referral; recreation; health counseling and counseling in general.	Supplemental funds, $18,783.	Yes.	State Commission on Aging.
Akron, Ohio.	CAA; Akron, Ohio.	Transportation.	Supplemental funds; $120,000.	Yes,	Unidentified.
Cincinnati, Ohio.	Senior Service, Inc.; Cincinnati, Ohio.	Home Aides; Meals-On Wheels; senior centers; nutrition programs.	Supplemental funds; $138,000; unspecified amounts from title III, AoA and Nutrition grant.	Yes.	Hamilton County Welfare Department.
Cleveland, Ohio.	Local CAA; City Health Department, Cleveland, Ohio.	Transportation and dental services.	CAA; $109,000; City Health Department, $178,000; total, $287,000.	Yes.	City Health Department.
Columbus, Ohio.	No specific program.				
Dayton, Ohio.	Fifth Street YMCA, Dayton, Ohio.	Recreation and educational programs.	Supplemental funds; $8,000.	Uncertain.	Unidentified.
Martins Ferry, Ohio.	Ohio Administration on Aging; RSVP-ACTION, Martins Ferry, Ohio.	RSVP; senior center; recreation.	Supplemental funds, $38,000.	Uncertain.	Unidentified.
Toledo, Ohio.	Warren Church, Bethel Senior Center, Toledo, Ohio.	Employment and health counseling; information and referral, meals.	Supplemental funds, $52,000.	Yes.	City Parks and Recreation Dept.
Youngstown, Ohio.	Western Reserve Authority, Youngstown, Ohio.	Transportation on an on-call basis.	Supplemental Funds, $24,000.	No.	

Milwaukee, Wis.	Project Involve; 836 North 12th St., Elder Care Line, Inc., 1214 North 13th St., Milwaukee, Wis.	Transportation.	Supplemental Funds, $255,000.	Uncertain.	Unidentified.
		HUD REGION VI			
Little Rock, Ark.	City Park and Recreation, 2500 East Capiton, Little Rock, Ark.	Arts and crafts; transportation and nutrition projects.	Supplemental Funds; $3,000; City, $21,000; total, $24,000.	Yes.	Unidentified.
Texarkana, Ark.	Senior Citizens' Food Service, 417 Olive St. or P.O. Box 619, Texarkana, Ark.	Meals-On-Wheels; recreational activities.	Supplemental Funds, $36,600. Texas and Arkansas Governors' CoAs, $36,600; Recipients' share, $6,406; total, $79,606.	Yes.	Unidentified.
New Orleans, La.	No program specifically for the elderly.	Only a reading program not designed for elderly.			
Santa Fe, N. Mex.	Santa Fe Senior Citizen Center, P.O. Box 4455, 509 Camino de los Marques, Sante Fe, N. Mex.	Senior center; Meals-On-Wheels; transportation; social activities.	Supplemental Funds; $40,000. OEO–CAPs, $12,000; title III, $50,000. County, $11,000; City, $9,000; total, $133,778.	Yes.	Unidentified.
Lawton, Okla.	Community Service Department of the Recreation Department, 103 South 4th St., Lawton, Okla. Senior Citizens' Multipurpose Center, 1201 Monroe St., Lawton, Okla.	Recreational activities; transportation; information and referral; home companionship; counseling and education.	Supplemental funds, $8,645; city and others, $1,669; Special unit on aging, $9,716; total, $20,030.	Yes.	Unidentified.

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
McAlester, Okla.	Salvation Army General Delivery, 400 North A St., McAlester, Okla.	Transportation and health services. Senior Center activities as well.	Supplemental funds, $12,000; Salvation Army, $8,462; total, $20,462.	Yes.	Unidentified.
Tulsa, Okla.	University of Oklahoma Extension Office, 423 Mayo Building, Tulsa, Okla.	Recreation center; nutrition program; social activities.	Supplemental Funds $110,572, University of Oklahoma, $28,419; total, $138,991.	Yes.	American Senior Citizens' Council.
Texarkana, Tex. combined with Texarkana, Ark.	Senior Citizens' Services of Texarkana, P.O. Box 619, Texarkana, Tex.	Delivered meals; visiting service.	Supplemental funds, $38,000; Texas and Arkansas Governors' CoA $38,000; Recipients' share, $6,227; total, $82,227.	Yes (Texas side only).	
Albuquerque, N. Mex.	Social Service, 610 Broadway SE., Albuquerque, N. Mex.	Working in field of nutrition; transportation; arts and crafts and music.	Supplemental funds, $91,000; other, $34,000; total, $125,000.	Yes.	Unidentified.
Austin, Tex.	Child & Family Services, Inc., 419 West 6th St., Austin, Tex.	Homemaker Project; transportation.	Supplemental funds, $48,000; Title IV–A, $110,000; total, $158,000.	No.	
Eaglepass, Tex.	City Social Services, Box TT, Eaglepass, Tex.	Homemaker; transportation; information and referral; recreation; counseling.	Supplemental funds, $42,000; Title IV–A, $68,000; total $110,000.	Yes.	City Social Services.
Edinburgh, Tex.	Associated City-County Economic Development of Hidalgo Co., 314 South Closner St., Edinburgh, Tex.	Senior Center; information and referral; comprehensive services.	Supplemental funds, $30,000; CAP, $30,000; total, $60,000.	Yes.	Senior Citizens' Board, Inc.
Houston, Tex.	Governor's Committee on Aging, 1902	Information and referral; transportation;	Supplemental funds $90,000; other	Yes.	Unidentified.

	Westheimer, Houston, Tex.	day care; Homemaker; counseling; health. Due to cutbacks in M.C. funds, cancellation is due in March.	church groups, $280,000; total, $370,000.		
Laredo, Tex.	Laredo-Webb Co. Health Department, 2600 Cedar St., Laredo, Tex.	Homemakers; health programs; transportation.	Supplemental funds, $30,242; Title I of S.S. Act, $56,909; Title IV of S.S. Act, $13,655; total, $100,806.	Yes.	Laredo-Webb Co. Health Dept.
San Antonio, Tex.	Office of Senior Citizens Services, 600 Hemisfair Plaza, San Antonio, Tex.	Day Care; nutritional counseling.	Supplemental funds $33,000 Title III OAA $64,677 City of San Antonio $3,218; $100,885.	Uncertain.	Unidentified.
Waco, Tex.	Heart of Texas Council of Governments, 216 North 5th St., Waco, Tex.	Studying Meals-On-Wheels and general problems of the Aging.	Texas COG $27,500.	Uncertain.	
		HUD REGION VII			
Des Moines, Iowa	City-County Health Armory Building, Des Moines, Iowa.	Nutrition program.	Supplemental funds, $51,000; HEW, $277,000; State agency on aging, $16,000; total, $344,000.	No.	
	Polk County Social Services, County Court House, Des Moines.	Homemaker services; escort services.	Supplemental funds, $59,000.	Yes.	HEW to fund for $177,000.
	Urban Development Corp., City Hall, Des Moines, Iowa.	Emergency Repair.	Supplemental funds, $350,000.	Yes.	Unidentified.
	Senior Citizen Service, 1721 Forest Ave., Des Moines, Iowa.	Recreation; transportation and in-home service.	Supplemental funds, $6,400; HEW, $60,000; total, $66,400.	Yes.	Unidentified.

HUD REGION VII—Continued

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Kansas City, Mo.	Human Resources, Corp., 1010 Truman Rd., Kansas City, Mo.	Social services; referral; arts and crafts; transportation.	Supplemental funds, $50,000; State Aging Agency, $150,000; United Fund, $500,000; total, $700,000.	No.	
St. Louis, Mo.	Social Services for the Elderly, Inc., 3501 Olive, St. Louis, Mo.	Protective services; social services; transportation; Homemaker services.	Supplemental funds, $146,906; HEW, $361,869; total, $508,775.	Yes.	Unidentified.
Wichita, Kans.	Senior Activities Center, Inc., 251 Indiana, Wichita, Kans.	Meals delivered; arts and crafts; social activities.	Supplemental funds, $39,999; united fund, $1,568; total, $40,767.	No.	

HUD REGION VIII

Denver, Colo.	Outreach Services for the Aged, Inc., 1825 Emerson, Denver, Colo.	Training the elderly to visit and help the isolated elderly of the area; transportation; day care; information and refereal.	Supplemental funds, $85,000; city commitment, $15,000; total, $100,000.	Uncertain.	Unidentified.
	Denver Department of Welfare, 320 West 8th Ave., Denver, Colo.	Homemaker services.	Supplemental funds, $56,670; HEW, $170,010; total, $226,680.	Yes.	State Funds.
Trinidad, Colo.	Senior Citizens Board 210 East Kansas, Trinidad, Colo.	Recreation; arts and crafts; hot meals; transportation; social activities.	Supplemental funds, $6,000; City and County, $8,500; Project Income, $3,000; total, $17,500.	Yes.	City and County and Project Income.

Butte, Mont.	Butte Senior Citizen Center, 405 West Park, Butte, Mont.	Health services; recreational activities; Outreach; friendly visiting.	Supplemental funds, $25,000; County Commission, $11,000; total, $36,000.	Yes.	Unidentified.
Helena, Mont.	Rock Mountain Dement Corp., 201 South Last Chance Gulch, Helena, Mont.	RSVP.	Supplemental funds, $3,000; ACTION, $26,728; total, $29,728.	Yes.	ACTION.
	Rocky Mountain.	Nutrition Program; lodging program; educational facilities; social activities; information and referral.	Supplemental funds, $22,000; HEW, $43,884; County Mill Levy, $20,000; total, $85,884.	Yes.	HEW; OAA Title III; County Mill Levy.
Fargo, N. Dak.	Fargo Park and Recreation District, 914 Main Ave., Fargo, N. Dak.	Outreach; Senior Center; Meals served; shopping service.	Supplemental funds, $17,275; Federal, $73,954; City, $42,732; total, $134,061.	Yes.	HEW and District grants.
Salt Lake City, Utah.	Department of Social Services, 2835 South Main, Salt Lake City, Utah.	Homemaker services; and visiting health services.	Supplemental funds, $40,000; Assisted Family Welfare Service, $120,000; total, $160,000.	Yes.	Dept. of Social Services of the County.
Cheyenne, Wyo.	Senior Citizens Club, 106 East 6th St., Cheyenne, Wyo.	Social services; meals; arts and crafts.	Supplemental funds, $1,000; Local club and highway funds, $1,150; total, $2,150.	Yes.	Unidentified.
		HUD REGION IX			
Gila Bend, Ariz.	No specific aging programs.				
Tucson, Ariz.	VNA; Mental Health Service; Jewish Community Center; Tucson I & R, Tucson, Ariz.	Home health; day care; social activities; nutrition; information and referral; Outreach.	Supplemental funds, $405,000.	Yes.	Unidentified.

Model City	Delegate agency	Specific services	Funding sources	Plan to continue	Future prime funding sources
Berkeley, Calif.	Berkeley City Social Planning Department, City Hall, Berkeley, Calif.	Senior Center; Meals-on-Wheels; recreation; arts and crafts; music.	Supplemental funds; $64,000.	Yes.	Unidentified.
Compton, Calif.	Parks and Recreation Department of the City of Compton, 600 North Alameda, Compton, Calif.	Transportation; four senior centers; arts and crafts; recreation; music; newsletter.	Supplemental funds, $35,000.	Yes.	Unidentified.
Fresno, Calif.	West Fresno Federation of Neighborhood Centers (Hinton), 450 Fresno St., Fresno, Calif.	Hot meals; senior center; social activities; information and referral.	Supplemental funds, $26,000; title III, $16,000; total, $42,000.	Yes.	Unidentified.
Los Angeles, Calif.	Los Angeles Unified School District Adult Education Division, 317 North Soto, Los Angeles, Calif.	Foster Grandparents; meals nutrition and health education; information and referral; Meals-on-Wheels.	Supplemental funds, $136,000; other, $4,100; total, $140,000.	No.	
	Watts Labor Action Committee, 8501 South San Pedro, Los Angeles, Calif.	Recreation; meals; information and referral; transportation.	Supplemental funds, $100,000; other, $26,500; total, $126,500.	Uncertain.	Unidentified.
Los Angeles County, Calif.	Department of Senior Citizens Affairs, Los Angeles, Calif.	Information and referral; Foster Grandparents; transportation.	Supplemental funds, $355,999; city/county, $110,407; total, $466,506.	Yes.	Unidentified.
	Department of Public Social Services.	Homemaker services; crises unit; volunteer project.	Supplemental funds, $140,671; HEW, $797,437; city/county, $132,525; other, $5,950; total, $1,076,583.	Yes.	Unidentified.

Pittsburg, Calif.	Community Health Center, 918 Railroad Ave., Pittsburg, Calif.	Transportation; social services; Outreach; information and referral; Client advocacy.	Supplemental funds, $76,000.	Yes.	Unidentified.
Richmond, Calif.	Contra Costa County County Administration Building, Martinez, Calif.	Planning and program development.	Supplemental funds, $11,000; title III, $41,000; total, $52,000.	Yes.	Unidentified.
San Diego, Calif.	San Diego City Department of Recreation, San Diego, Calif.	Four Senior Centers; Outreach; transportation; meals.	Supplemental funds, $150,000; City, $55,000; total, $205,000.	Yes.	Negotiations with City and County.
San Francisco, Calif.	No specific program.[1]				
San Jose, Calif.	Eastside Center, 2070 Alumrock Ave., San Jose, Calif.	Counselling, recreation; arts and crafts; nutrition; transportation; telephone reassurance; Homemaker.	Supplemental funds, $45,000; Catholic Charities, $42,000; total, $87,000.	Yes.	Unidentified.
Honolulu, Hawaii.	No aging programs.				

HUD REGION X

Juneau, Alaska.	Catholic Charities, Juneau, Alaska.	Proposal to fund a senior center.	Supplemental funds, $20,000; title III, $50,000; total, $70,000.	Uncertain.	
Boise, Idaho.	Senior Citizens' Transportation Project, Boise/Winnemuca States Bus Co., Boise, Idaho.	Retirement Jobs, Inc.; transportation; meals; Homemaker; information and referral.	Supplemental funds, $31,200; title III, $5,000; Volunteer Funds, $2,000; total, $38,200.	Uncertain.	
Portland, Oreg.	Senior Adult Services Commission on Aging, Portland Model Cities Program, 5329 NW. Oregon, Portland, Oreg.	Information and referral; handyman; telephone reassurance; Outreach; transportation.	Supplemental funds, $223,893.	Yes.	

See footnote at end of table.

HUD REGION X—Continued

Model City	Delegate agency	Special services	Funding sources	Plan to continue	Future prime funding sources
Seattle, Wash.	Comprehensive Services for Elderly, Inc., Seattle, Wash.	Handyman; Homemaker; employment of the elderly; Drop-in center.	Supplemental funds, $90,000.	Yes.	
Tacoma, Wash.	City Association of Colored Women's Clubs, Tacoma, Wash.	Senior Citizens Program.	Supplemental funds, $47,726.	Yes.	

[1] According to the San Francisco Model Cities Agency, they have no program at present to benefit the elderly.

Appendix 3

COMMITTEE HEARINGS AND REPORTS

No asterisk indicates single copy available from committee and multiple copies available for purchase from U.S. Government Printing Office.

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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.**
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- Part 8. Washington, D.C., August 2, 1972 (45¢).
- Part 9. Boston, Mass., October 2, 1972 (45¢).

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[1] Working paper incorporated into appendix of hearing.

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Part 1. Washington, D.C., August 7, 1972 (30¢).
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OTHER DOCUMENTS AVAILABLE

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"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.**

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CSA.—"Legislative History of the Older Americans Comprehensive Services Amendments of 1972," prepared by Special Committee on Aging and Subcommittee on Aging of the Committee on Labor and Public Welfare, December 1972.

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L-T.—"Trends in Long-Term Care," Subcommittee on Long-Term Care of the Special Committee on Aging, Part 20 (Access of Minority Groups to Nursing Homes), Washington, D.C., August 10, 1972.

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AoA—Evaluation of Administration on Aging and Conduct of White House Conference on Aging.
Dth—Death With Dignity.
Hsg—Adequacy of Federal Response to Housing Needs of Older Americans.
L-T—Trends in Long-Term Care.

AgL—Action on Aging Legislation in 92d Congress.
CC—Cancelled Careers.
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