93D CONGRESS
2d Session

SENATE

REPORT
No. 93-846

DEVELOPMENTS IN AGING: 1973 AND JANUARY-MARCH 1974

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 51, FEBRUARY 22, 1973

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

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LETTER OF TRANSMITTAL

MAY 13, 1974.

HON. GERALD R. FORD,
President of the Senate,
Washington, D.C.

DEAR MR. PRESIDENT: As required under Senate Resolution 51, dated February 22, 1973, I am submitting to you the annual report of the Senate Special Committee on Aging, "Developments in Aging: 1973 and January-March 1974."

Publication has been delayed this year to allow some discussion of major new developments in the field of aging, including House action on private pension reform and new initiatives for national health insurance. Additional time was also required for completion of minority views.

Senate Resolution 267, passed unanimously by the Senate on March 1, 1974, 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 want to extend my thanks to the officers of the Senate for the cooperation and courtesies extended to us.

Sincerely,

FRANK CHURCH, *Chairman.*

SENATE RESOLUTION 51, 93d CONGRESS
1st SESSION

Resolved, That the Special Committee on Aging, established by S. Res. 33, Eighty-seventh Congress, agreed to on February 13, 1961, as amended and supplemented, is hereby extended through February 28, 1974.

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, 1973, through February 28, 1974, 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, 1974. The committee shall cease to exist at the close of business on February 28, 1974.*

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. 267, agreed to March 1, 1974 extended the committee through February 28, 1975.

PREFACE

Inflation—always a threat to older Americans—has become even more of a daily problem since the last report of this committee was issued.

As described in this report, the elderly have been hard-hit by the irregular upward surges in prices.

It's more than the traditional impact of inflation upon persons with fixed income. It also means that prices are rising markedly in several budget areas of special importance to older Americans: food, shelter, and health care. A gasoline shortage, while alleviated greatly within recent weeks, has nevertheless left a legacy of concern to the elderly in particular: high gasoline prices, with the prospect of still higher prices to come.

Congress, which had approved a 20 percent Social Security increase in 1972 and an automatic cost-of-living adjustment mechanism to take effect next January, found it necessary in 1973 to enact a two-part, 11 percent raise for 1974. Increases in Supplemental Security Income levels were also voted.

Despite the congressional initiatives in response to inflationary pressures, much more remains to be done if we are to develop an overall income strategy worthy of a great Nation.

Part of our shortfall can be expressed in terms of average monthly Social Security benefits. Even with the new 11 percent increase, these levels will be:

—$181 for the typical retired worker;
—$310 for a retired couple; and
—$177 for an aged widow.

Another measure of inadequacy is the extraordinarily high incidence of poverty among the elderly: about 3.5 million have incomes below the official poverty indexes. If the hidden poor were also counted, this number would swell to more than 5 million.

To deal with that problem and with the overall challenge of retirement income, I have my own set of goals:

First, I believe that we should end poverty once and for all among older Americans. It is intolerable that the elderly must pay so personal a price for vast economic changes not of their making. Many who have been poor most of their lives deserve help now. Those who were not poor until they became old must be rescued from economic despair. And so, our first priority should be to improve the Supplemental Security Income program, which went into effect at the start of this year. It should be broadened and upgraded until it brings all older Americans who need it above bare poverty standards.

Second, the Nation should adopt a goal of "adequacy" for retirement income drawing upon Social Security, private pensions, and other sources for a reasonable "mix." At our hearings on "Future Di-

rections in Social Security," we are paying special heed to the potential role of each of the components in this "mix."

Third, the Social Security system should be re-examined with a greater eye to social justice. The payroll tax now bears heavily upon low-income groups, and many minority members in that group don't live long enough to collect benefits. Proposals for greater equity are being considered at the "Future Directions" hearings, along with suggestions for more sensible treatment of women.

Health Issues

A second great challenge to the elderly of this Nation—and to the people who care about the elderly—is the need for comprehensive health care.

That, of course, is what many people thought Medicare was all about, when it was enacted in 1965. I supported Medicare then and I support it now. But I think that the Medicare of 1974 falls far short of what is needed. Coverage has dwindled, and the cost to the participant has gone up.

Look at what has happened. The monthly premium for doctor fees under Medicare was $3 in 1966 and it now stands at $6.30. The deductible—a kind of down payment on the hospital bill the patient must pay—was $40 in 1966 and now it is $84. Coinsurance, the part of the hospital bill the patient pays after 60 days, has gone from a daily rate of $10 to $21 for persons hospitalized from 61 to 90 days.

These charges make a deep dent in retirement budgets, but they reflect only a portion of the high costs of health care for older Americans. Uncovered by Medicare are such necessities as out-of-hospital prescription drugs, dental services, eyeglasses, and hearing aids. Today just about 40 percent of the cost of medical care for the elderly is covered by the Medicare program.

Another problem is the damaging effects caused by the drastic curtailment of in-home services. I'm speaking about carefully managed home health programs which can enable many ill or incapacitated persons to remain at home. There is reason to believe that in-home services, when appropriate, can save dollars. More important, in-home services can prevent family disruption and needless placement in an institution.

And yet, because of restrictive HEW policies since 1969, the number of home health agencies has declined and the percentage of Medicare funds for their services is now less than 1 percent.

It is unfortunate that the President's proposal for a Comprehensive Health Insurance Plan fails to counteract this trend. In fact, his proposal would actually reduce the number of allowable home health visits.

Other Issues

Every year, new issues arise in the annual report of the United States Senate Special Committee on Aging.

The emergence of new issues can be healthy, a sign of growth in interest and support.

But often issues arise because of failures of policy or even contradictions in policy and actions.

The pages of this report provide facts on many such issues. They tell, for example, of the beginning phases of a new approach for service delivery under the Older Americans Act, as well as the start of the Nutrition for the Elderly program. Important questions are already emerging for these programs and others.

Such developments are described, and rightly so, as an uneven mix of progress and problems arising in Federal actions and policies affecting older Americans.

It will be the job of the Senate Committee on Aging—as well as other congressional units—to keep watch over these developments, to fight inflation in the face of administration drift, and to work toward the day when the positive aspects of aging in this Nation achieve at least as much attention as the negative aspects.

Many times in my travels around the Nation, I look over local newspapers and am surprised by the constant repetition of a headline which usually says: "Plight of Elderly Described."

It is almost a reflex action. An editor picks up a story related to aging and he immediately assumes that it must be a sad story. Quite often, he's right. But occasionally, he fails to spot the good news that is occurring more and more among older Americans.

My hometown newspaper in Idaho is a happy exception to the rule. It is constantly publishing stories about very affirmative actions taken by Idaho people who happen to be old. In Boise, for example, a group called "Extra Years of Zest" has a very far-reaching program which allows older persons to help other elderly individuals in a wide number of inventive and often cheerful ways.

In this report, there are other encouraging accounts of progress and good works by and for older Americans. This committee—while recognizing the formidable challenges of aging—should also pay heed to the fortunate developments as well.

They are part of the story, too. And they help us to see there are many paths toward the goal we all seek: a Nation in which older persons enjoy their fair share of life's economic returns and life's satisfactions, as well.

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 (65+)—comprising 4 percent of the total population or every twenty-fifth American. As of mid-1972, some 21 million older persons made up 10 percent of the total population—every tenth American.

The largest concentrations of older persons—12 percent or more of a State's total population—occur in 7 States in the agricultural midwest and in Florida. New York, California, Pennsylvania, Florida, Illinois, Texas, and Ohio each have more than a million older people. 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+.

A quarter of the older population lives in just 3 States (New York, California, and Pennsylvania). Adding 5 more States (Florida, Illinois, Texas, Ohio, and Michigan) brings the 8 State total equal to half the older people in the United States. It takes 11 more States (a total of 19) to account for three quarters of the older population and an additional 11 (a total of 30) to include 90 percent. The remaining 21 States have the remaining 10 percent of the 65+ population.

What is this population like, and how does it change?

GROWTH IN NUMBERS

During the 70 years between 1900 and 1970, the total population of the United States grew to almost 3 times its size in 1900 while the older part grew to almost 7 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 in-migration, had the highest proportion of older people in 1970—14.5 percent (estimated 15.5 percent in 1972) while New York had the largest number of older people in 1970, 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.

[1] Prepared by Herman B. Brotman, Consultant to the Special Committee on Aging, United States Senate, and former Assistant to the Commissioner on Aging.

ON AGE

As of mid-1973, most older Americans were under 75 (62 percent); half were just under 73; more than a third (36 percent) were under 70. Between 1960 and 1973, the population aged 65 through 74 increased 20 percent but the population aged 75+ increased 46 percent. More than 1.6 million Americans are 85 years of age or over. Accurate data on the number of centenarians is not available but more than 7,000 persons who produced some proof of age are aged 100+ and receiving Social Security benefit payments.

ON HEALTH

Eighty-one percent get along well on their own. While only 14 percent have no chronic conditions, diseases, or impairments of any kind, the vast majority that do have such conditions still manage by themselves. Older individuals are subject to more disability, see physicians 50 percent more often, and have about twice as many hospital stays that last almost twice as long than do younger persons.

In fiscal year 1973, per capita health care costs for older Americans came to $1,052, exactly 3½ times the amount ($300) spent for each under-65 person, $509 went for hospital care, $186 for physician services, $35 for other professional services, $97 for drugs, $149 for nursing home care, and $76 for other items. Older people represent 10 percent of the population but account for 28 percent of personal health care expenditures. Of the health care costs for older persons, close to $680 of the $1,052 total (64.5 percent) came from public program resources. Medicare covered 40.3 percent (about $425) of the total costs per older person.

ON PERSONAL INCOME

Older persons have less than half the income of their younger counterparts. In 1972, half of the families headed by an older person had incomes of less than $5,968; the median income of older persons living alone or with nonrelatives was $2,397. Some 3.7 million or about a fifth of the elderly lived in households with incomes below the official poverty threshold for that kind of household. This was a considerable improvement over the close to 5 million in 1970 and results from the increases in Social Security benefits. Women and minority aged are overrepresented 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. About half of the aged couples could not afford the costs of the theoretic retired couple budget prepared by the Bureau of Labor Statistics for a "modest but adequate" standard of living.

ON EXPENDITURES FOR CONSUMPTION

Older Americans spend proportionately more of their income on food, shelter, and medical care and less on other items in a pattern generally similar to that of other low income groups. Persons living on fixed incomes are hit hard by price inflation and command little potential for personal adjustment of income. Even formulas that adjust retirement payments for changes in price indices are of only partial

assistance since they bring increases after the fact and older people have little savings to carry them over until income is increased.

ON LIFE EXPECTANCY

Based on death rates in 1972, average life expectancy at birth was 71.2 years; 67.4 for men but close to 8 years longer or 75.2 years for women. At age 65, average remaining years of life were 15.3; 13.1 for men but 4 years longer or 17.2 years for women. The 27-year increase in life expectancy since 1900 results from the wiping out of most of the killers of young people; much less improvement has occurred in the upper ages. More people now reach old age but once there, they do not live much longer than did their ancestors who reached such age in the past.

ON SEX RATIOS

Most older persons are women—12.5 million as compared to 8.8 million men in mid-1973. Between ages 65 and 75, there are 130 women per 100 men; after 75, there are 166. The average for the total 65+ group is 142 women per 100 men.

ON MARITAL STATUS

Most older men are married; most older women are widows. There are almost 4 times as many widows as widowers. Of the married men, almost 40 percent have under-65 wives. In a recent year, there were about 14 thousand marriages where both bride and groom were 65+, about 2 thousand marriages where only the bride was 65+, and about 22 thousand marriages where only the groom was 65+.

ON EDUCATION

In 1972, almost half of the older Americans had not completed 8 years of elementary school. More than 2 million older people were "functionally illiterate", having had no schooling or less than 5 years. About 7 percent were 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 wife but only one-third of the older women live in families that include their husband. About a quarter of older women head their own household or live in the home of a relative. One third of all older women live alone. Three times as many older women live alone or with nonrelatives as do older men.

ON PLACE OF RESIDENCE

In 1970, a somewhat smaller proportion of older persons than of younger persons lived in metropolitan areas (64 vs 69 percent). Within the metropolitan areas, however, most (53 percent) older people

lived in the central city while most (55 percent) under-65 people lived in the suburbs.

ON VOTING

In the 1972 elections, older people were 15 percent of both the voting age population and of the number of people who voted. About 63 percent of the older population voted, the same as the average for all ages, but that average covers a range from low (48 percent of under-21 persons) to a high (71 percent of persons aged 45–64).

ON MOBILITY

In the year ending March 1971, 8.7 percent or 1.7 million older persons moved from one residence to another. Six percent moved within 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. The extent of interstate movement is exaggerated because much migration tends to flow toward a very small number of States like Florida, Arizona, or Nevada.

ON EMPLOYMENT

In 1973, about 23 percent of 65+ men (1.9 million) and 9 percent of 65+ women (1.1 million) 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 discouraged older workers stop seeking jobs and leave the labor market. For those remaining actively in the labor force and counted as unemployed, the average length of unemployment was greater than for younger workers.

ON AUTOMOBILE OWNERSHIP

As is true for most major household appliances, ownership of automobiles by older households is considerably below that of households with younger heads but a good part of the explanation rests with income level rather than health or choice. A 1972 survey shows that the lowest proportion of households owning one or more cars was for those with 65+ heads (58 percent) and the highest was for those with 35–44 heads (88 percent). However, only among the households with under $5,000 incomes was there a decrease in automobile ownership with advancing age. In the over $5,000 per year income households, there were practically no differences by age. Some 92 percent of elderly households with $15,000+ annual incomes owned at least one automobile.

93D CONGRESS 2d Session } SENATE { REPORT No. 93-846

DEVELOPMENTS IN AGING: 1973 AND JANUARY-MARCH 1974

MAY 13, 1974.—Ordered to be printed

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

REPORT

TOGETHER WITH MINORITY VIEWS

[Pursuant to S. Res. 51, 93d Cong.]

INTRODUCTION

Once again in 1973, an uneven mix of progress and problems marked Federal actions and policies affecting older Americans.

The most significant fact of everyday life for many elderly persons was that inflation continued its dramatic rise, sharply reducing the effectiveness of a 20 percent Social Security rise voted by the Congress in 1972.

Steady cost-of-living increases impelled the Congress last year to vote a 2-part increase for 1974 instead of waiting for a later automatic cost-of-living mechanism (scheduled to become effective in January 1975) to reflect higher prices, as provided for under the 1972 legislation.

At the same time that inflation forced action on Social Security benefits, legislators in both Houses of Congress resisted an administration proposal which would have considerably increased costs of Medicare for the older persons who rely on that program for protection against disastrous medical bills. Early in 1974, a similar proposal—this time tied to the administration's Comprehensive Health Insurance Plan (CHIP)—was advanced by the President. It, too, was greeted skeptically by those concerned about its impact upon Medicare.

Instead of reducing Medicare effectiveness, said members of the Senate Committee on Aging, efforts should be made to improve it. Chairman Frank Church and Subcommittee on Health Chairman Edmund Muskie introduced legislation, for example, which would improve home health care services under Medicare.

On another front in the health care scene, administration regulations related to nursing home care came under sharp scrutiny and

criticism throughout the year, raising far-reaching questions about administration intentions and strategies related to long-term care.

Perhaps the most dramatic—and the most negative—development of the year was the moratorium on housing and related programs put into effect early in 1973. The effect was disruption and uncertainty about housing programs which had been serving, even to a limited degree, the elderly. The uncertainty was not resolved by an administration plan, issued in September 1973, which may provide large scale housing allowances in conjunction with a leased housing program. Faced by what appeared to be an inadequate administration plan, members of Congress were advancing their own legislation to provide housing for the elderly.

Problems also arose in 1973 in the gearing-up and early implementation of a broadened and considerably revamped Older Americans Act, together with a Nutrition for the Elderly program. Early in 1974, it was difficult to assess whether these problems were the normal difficulties to be expected in the early months of major new programs, or whether fundamental questions were still unresolved. In addition, an energy crisis introduced new perplexities to the scene. At the same time, a sharply defined dispute between the administration and the Congress arose on another crucial issue: training for careers in aging. The controversy—centering around administration intention to substitute short-term for long-term training and to stretch out over a 2-year period funds already provided by the Congress for 1 year—was not resolved as this report neared publication.

THE POSITIVE DEVELOPMENTS

Complications and problems aside, 1973 was also a year in which important, positive developments took place.

A major step forward in the evolution of a national policy to assure retirement security for all began in January 1974 when the Supplemental Security Income program went into effect, replacing the old, inequitable old-age assistance program. Benefits were still too low, and serious administrative problems arose as the program took hold; but the principle of a nationwide floor under retirement income was established.

Congress also took major steps toward reforming private pension coverage, a vital requirement for improving the retirement income situation of this Nation.

Despite inflationary pressures, the work done by the Congress in improving Social Security within recent years now makes it possible to plan long-range actions to make the system even more useful than it now is. This possibility has led the Committee on Aging to examine "Future Directions in Social Security." That study will continue in 1974 and possibly beyond. Another significant development is the introduction of legislation intended to establish an independent Social Security Administration.

Troublesome as the implementation of the 1973 Older American Amendments and the nutrition program may be, the nation may finally be on the road toward development of a genuine social service delivery network of direct usefulness to the elderly and possibly other

Americans as well. The way will not be easy, because program directors and strategists are working in largely uncharted territory. The United States has never had a "retirement revolution" before; something new is needed, in ideas and in actions.

Despite cutbacks in other areas, the administration has asked—two years in a row—for substantial sums for the Older American Amendments and the nutrition program. Thus, continuing support for the overall Older Americans Act seems assured at a crucial point in its development. (The nutrition program, Title VII, of the Older Americans Act, is up for renewal by June 30 of this year; the other components of the Older Americans Act will be up for renewal a year later.)

Another development was the appointment and confirmation of Dr. Arthur Flemming—former Secretary of Health, Education, and Welfare—as U.S. Commissioner of Aging in 1973. Dr. Flemming has taken several steps intended to encourage interdepartmental action and other high-level attention to aging.

Finally, the Congress remains firm in its support of the nutrition program and the Older Americans Act. Appropriations have been larger than requested by the administration; a 3-year extension of the nutrition program was passed by the House in March 1974 even though the Administration recommended only one year.

One of the most encouraging developments was the evident growth of interest in aging, not only in the United States but elsewhere in the world. One sign of concern was a United Nations survey calling for greater international attention to what it described as an "aging population" in developing nations, as well as the more industrialized nations.

SUMMARY OF MAJOR CONCERNS

This report discusses the developments briefly described in this introduction and also calls for:

- A more comprehensive and more equitable retirement income system in the United States, with early action to end poverty among the 3.5 million elderly still below official poverty levels.
- Actions to improve Medicare, not weaken it, in order to assure that the elderly will be well-served by whatever national health plan for all age groups may be adopted in the years ahead. Special attention must be paid to long-term care, now the subject of sharp debate about recent policy shifts expressed in proposed regulations.
- Prompt action should be taken on congressional proposals to end the damage done by last year's housing moratorium by enacting broad legislation including programs designed to meet the real housing needs of older Americans.
- Congress must maintain close watch over implementation of the Older Americans Act programs to assure flexibility and clear progress toward specific goals.

PART ONE

CHAPTER I

INCOME, INFLATION, AND THE ADVENT OF SSI

Older Americans, by and large, were still running a losing race with inflation during 1973, despite historic enactments that had been made during the previous year to raise and protect retirement income.

The 1972 record of legislative accomplishment had included a number of significant breakthroughs:

- Social Security benefits were boosted by 20 percent, the largest dollar raise, by far, in the history of the program.[1]
- A new cost-of-living adjustment mechanism was approved to help make Social Security "inflation-proof" for the aged.[2]
- Higher Social Security payments were voted for nearly 3 million elderly widows, one of the most economically disadvantaged groups in our society.[3]
- A new Supplemental Security Income program was established which would, for the first time, build a Federal floor under the incomes of the aged.[4]
- The retirement test was liberalized to permit the elderly to earn more before their Social Security payments would be reduced.[5]
- A special minimum monthly benefit was enacted for persons with low lifetime earnings and long periods of covered employment.[6]
- Railroad Retirement annuities were also boosted by 20 percent.[7]

And so, as 1973 began, it seemed that the big tasks ahead lay in new directions related to retirement security: tax reform, national health insurance, constitutional issues related to impoundment, and development of a service delivery system which, as one of its goals, could help prevent needless institutionalization of many older persons.

But unforeseen inflationary forces intervened.

Congress discovered that it could not wait for the automatic adjustment mechanism because the cost-of-living was climbing too fast. Congress acted twice, first in June with a 5.9 percent and then again in December with a substitute 2-step, 11 percent Social Security benefit increase to take effect in 1974.

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[1] Public Law 92–336, approved July 1, 1972.
[2] Public Law cited in footnote 1.
[3] Social Security Amendments of 1972, Public Law 92–603, approved October 30, 1972.
[4] Public Law cited in footnote 3.
[5] Public Law 92–603 increased the annual earnings limitation for persons under 72 from $1,680 to $2,100 effective in 1973. For earnings in excess of this amount $1 in benefits would be withheld for each $2 of wages. Under prior law this $1-for-$2 feature applied only to a $1,200 band of earnings between $1,680 and $2,880. Thereafter, Social Security benefits were reduced for each dollar of earnings above $2,880. Public Law 93–66 raised the annual exempt earnings limitation to $2,400 effective in 1974.
[6] Public Law cited in footnote 3.
[7] Public Law 92–460 became law without the signature of the President, two-thirds of the Senate and House voting to override the Presidential veto.

Even so, the nation still had to face this harsh fact: as many as five million elderly individuals—nearly one-fourth of all persons of age 65 or over in this nation—still live in poverty in 1974.

High hopes for SSI—the new Supplementary Security Income program designed to replace the inadequate and inequitable old-age assistance program—were daunted somewhat by problems arising in the early stages of implementation.

It is still too early, however, to determine whether those problems are unmanageable or whether they are the transitory impediments which appear when important new social advances begin to take hold.

I. WHY A SOCIAL SECURITY INCREASE IN 1973

In early 1973 the prevailing thought in the field of aging was that few, if any, improvements would be enacted for the Social Security program. After all, benefits had been increased by 52 percent [8] during the past 3 years. And, a new cost-of-living mechanism had been built into the program to raise Social Security automatically, provided two conditions were met:

1. The Consumer Price Index had increased by at least 3 percent during a base period; and
2. Legislation increasing Social Security benefits had neither been enacted nor had become effective during the previous year.

But as enacted under the cost-of-living legislation (Public Law 92–336) in 1972, the first automatic adjustment would not become effective until January 1975. In addition, inflationary pressures intensified early in 1973, particularly after the administration switched from Phase II to Phase III of its economic program.

By June 1973 the inflationary rate during the past year (5.9 percent) had already outstripped the automatic cost-of-living increase in Social Security benefits initially projected (5.1 percent) for January 1975.

In June the Senate approved an amendment to the debt ceiling bill (H.R. 8410) to provide a cost-of-living increase effective in January 1974 to cover the increase in the Consumer Price Index between June 1972 and June 1973.[9] This proposal was to be in the nature of a downpayment on the cost-of-living raise effective for January 1975 under Public Law 92–336. On June 29 the House Ways and Means Committee reported the bill back in disagreement. A motion was then offered by Representative Mills, Chairman of the Ways and Means Committee, to concur in the Senate amendments (relating to Social Security, Medicaid, social services, the Supplemental Security Income program, and other matters) with a further amendment. The effect of the Mills motion was to move back the effective date of the Social Security increase from January 1974 to April 1974. This compromise was offered largely because of the administration's strong opposition

[8] Social Security benefits were increased by 15 percent effective in 1970, 10 percent in 1971, and 20 percent in 1972. These increases total 45 percent. But because of the compounding effect, the aggregate increase amounts to 52 percent.

[9] The Senate approved the increase by a vote of 86 to 7. (Cong. Rec., June 27, 1973, p. S12140.)

to any Social Security raise effective in fiscal 1974. However, the House rejected the motion by a vote of 185 to 190.[10]

Hours later, members of the Senate Finance Committee and the House Ways and Means Committee met to develop an alternative approach, which would be more acceptable from the administration's standpoint. An agreement was eventually reached on a June 1974 effective date as the first installment on the scheduled January 1975 cost-of-living increase. That measure passed the House and Senate on June 30 as an amendment to the Renegotiation Act Amendments, H.R. 7445. The entire package was later signed into law (Public Law 93–66) on June 9.

A. The Church Proposal

But prices continued to shoot ominously upward during the summer months, especially the cost of food. And congressional sentiment for recasting the 5.9 percent Social Security increase gained further momentum.

On September 10, Senator Church introduced legislation (S. 2397) to provide a 7 percent Social Security increase, effective in January 1974. His measure, which eventually was cosponsored by 58 Senators,[11] was to be a substitute for the 5.9 percent raise (effective in June 1974) under Public Law 93–66.

Senator Church gave this rationale for his proposed course of action:

> With inflationary pressures continuing to intensify, an earlier and larger social security cost-of-living raise is urgently needed.
>
> The elderly cannot afford to wait much longer. Time is clearly not on their side.
>
> Last month's recordbreaking 6.2-percent jump in the wholesale price index provides an ominous warning that older Americans may experience still more increases in prices in the months ahead.
>
> All age groups have felt the harmful effects of spiraling inflation in one form or another. But older Americans struggling on limited, fixed incomes have been harder hit than any one else.[12]

Church also warned that the price of food could increase by almost 20 percent in 1973 alone. He noted that the cost of food had jumped

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[10] Congressional Record, June 29, 1973, p. H5727.

[11] Cosponsors of S. 2397 included Senators Gravel (Alaska), Fulbright (Arkansas), Cranston (California), Tunney (California), Haskell (Colorado), Ribicoff (Connecticut), Weicker (Connecticut), Biden (Delaware), Chiles (Florida), Gurney (Florida), Inouye (Hawaii), Stevenson (Illinois), Percy (Illinois), Bayh (Indiana), Hartke (Indiana), Clark (Iowa), Hughes (Iowa), Dole (Kansas), Cook (Kentucky), Huddleston (Kentucky), Muskie (Maine), Hathaway (Maine), Mathias (Maryland), Kennedy (Massachusetts), Brooke (Massachusetts), Hart (Michigan), Mondale (Minnesota), Humphrey (Minnesota), Eastland (Mississippi), Eagleton (Missouri), Metcalf (Montana), Mansfield (Montana), Bible (Nevada), Cannon (Nevada), McIntyre (New Hampshire), Williams (New Jersey), Case (New Jersey), Montoya (New Mexico), Domenici (New Mexico), Javits (New York), Burdick (North Dakota), Hatfield (Oregon), Schweiker (Pennsylvania), Pell (Rhode Island), Pastore (Rhode Island), Hollings (South Carolina), Abourezk (South Dakota), McGovern (South Dakota), Bentsen (Texas), Moss (Utah), Stafford (Vermont), Jackson (Washington), Magnuson (Washington), Randolph (West Virginia), Byrd (West Virginia), Nelson (Wisconsin), McGee (Wyoming).

[12] Congressional Record, September 10, 1973, p. S16155.

by almost 12 percent for the first 7 months of 1973. He added: "It is no wonder that surging food prices have had the effect of obliterating—or largely negating—the 20-percent Social Security increase [13] which was enacted into law in July 1972." [14]

The essence of the Church proposal was later adopted as an amendment to other legislation under consideration by the Senate Finance Committee and the House Ways and Means Committee.[15] On November 9 the Ways and Means Committee reported out a two-step, 11 percent increase [16] (an interim 7 percent raise effective in March 1974 as a downpayment on a permanent 11 percent increase effective in June 1974), after beating back a Nixon Administration substitute for a 10 percent raise effective in June 1974. Administration officials expressed immediate concern that the committee proposal would add to the deficit under the unified budget, and even threatened vetoes. An article in the November 15 edition of the *Wall Street Journal* [17] expressed administration concern and also indicated that a veto of the bill may be politically risky because it would pass the Congress by overwhelming margins. In discussing the reasons for taking this action, the Ways and Means Committee report said:

> When the Social Security Amendments of 1972 (Public Law 92–603) were enacted a little over a year ago, the amount of the automatic benefit increase for January 1975 was estimated to be 5.1 percent. When Public Law 93–66 was enacted in July of 1973, it was estimated that the first automatic benefit increase would be between 7.1 percent and 8.5 percent, as a result of continued high increases in the cost of living. The amount of the automatic benefit increase for January 1975 is now estimated to be 11.5 percent.[18]

On December 21 the Senate unanimously passed H.R. 11333 [19] with minor amendments. The House concurred in those amendments,[20] clearing the measure for the White House. President Nixon signed the bill into law (Public Law 92–233) on December 31, 1973.

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[13] Senator Church was the author of the 20-percent Social Security increase. See footnote 1.

[14] Page S16155, Congressional Record cited in footnote 12.

[15] On November 21, 1973, the Senate Finance Committee reported out H.R. 3153 which provided a two-step, 11 percent increase: seven percent effective the month of enactment as an installment on a permanent 11 percent raise (S. Rept. 93–553). On October 5, the Senate Finance Committee had initially agreed to a seven percent increase (effective the month of enactment) as an amendment to H.R. 3153.

[16] H. Rept. 93–627 to accompany H.R. 11333 (Social Security Benefit Increase) November 9, 1973.

[17] *Wall Street Journal,* November 15, p. 5. The article stated:

"It still isn't known, however, whether the White House will veto such legislation. Some Nixon administration officials have expressed concern that the legislation would add over $1 billion in outlays to the current fiscal year's budget.

"But the Social Security bill probably will pass both Houses by wide margins, making any veto politically risky for the President."

[18] Page 5 of report cited in footnote 16.

[19] The Senate approved H.R. 11333 by a vote of 66 to 0. Congressional Record, December 21, 1973, p. S23805.

[20] The House passed H.R. 11333, as amended by the Senate, by a vote of 301 to 13. Congressional Record, December 21, 1973, p. H11960.

II. MAJOR COSTS FOR THE ELDERLY: THE IMPACT OF INFLATION

Food, housing, transportation, and medical care account for the bulk of expenditures for most older Americans. In fact the most recent Bureau of Labor Statistics Intermediate Budget for a Retired Couple allocates about 80 percent—or $4 out of every $5—for these four essential items. And the proportion is even greater for the lower budget: 83 percent (or $5 out of every $6) is earmarked for these purposes.

Summary of annual budgets for a retired couple at 3 levels of living, urban United States, autumn 1972

Component	Lower budget	Intermediate budget	Higher budget
Total budget	$3, 442	$4, 967	$7, 689
Total family consumption	3, 294	4, 661	6, 842
Food	989	1, 328	1, 671
Housing	1, 209	1, 745	2, 730
Transportation	230	448	811
Clothing	172	289	445
Personal care	101	148	217
Medical care	432	434	437
Other family consumption	161	269	531
Other items	148	298	584
Personal income taxes		8	263

Source: Bureau of Labor Statistics, Department of Labor, 1973.

A. Income and Buying Power of the Elderly

1973 census data indicated that the median income for older Americans continued to improve. However, their buying power was considerably below that of younger Americans. A census survey in March 1973 revealed that the median income for a two-person aged household was $5,487 (or about $106 a week), compared with $11,861 (more than $228 a week) for a two-person household with a head in the 25 to 44 age category. And nearly one-third (31.1 percent) of all aged households struggled on less than $4,000 a year (less than $80 per week).

Age of head and size and type of family—families by total money income in 1972 [1]

Size of family	Number (thousands)	Percent distribution									
		Total	Under $1,000	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,499	$2,500 to $2,999	$3,000 to $3,499	$3,500 to $3,999	$4,000 to $4,999	$5,000 to $5,999
ALL FAMILIES											
Total	54,373	100	1.3	0.9	1.3	1.7	2.0	2.3	2.2	4.9	5.0
Head under 25 yr	4,194	100	3.1	2.0	2.2	2.9	3.3	3.9	2.8	8.4	8.5
2 persons	2,013	100	4.4	1.8	2.0	3.6	3.8	4.0	2.3	7.5	7.5
3 persons	1,474	100	2.0	2.2	1.7	1.7	2.8	3.4	3.5	9.8	9.7
4 persons or more	707	100	1.5	2.5	3.8	3.3	2.7	4.8	2.6	8.1	8.8
Head 25 to 44 yr	22,664	100	1.1	.7	.8	1.1	1.2	1.5	1.4	3.3	3.9
2 persons	3,584	100	1.8	1.4	1.1	1.2	1.5	1.6	1.6	3.7	4.0
3 persons	4,503	100	1.2	.8	1.2	1.5	1.9	1.9	1.7	3.0	4.7
4 persons	6,415	100	.8	.6	.6	.8	.9	1.6	1.1	2.8	3.1
5 persons	4,257	100	.7	.3	.6	.9	.9	1.1	1.3	3.0	3.2
6 persons or more	3,906	100	1.0	.3	.8	1.2	1.2	1.5	1.8	4.6	4.9
Head 45 to 64 yr	19,925	100	1.1	.7	1.1	1.2	1.1	1.5	1.5	3.2	3.6
2 persons	8,220	100	1.7	1.0	1.7	1.9	1.6	1.8	2.1	4.2	4.7
3 persons	4,649	100	.7	.5	.9	.9	1.0	1.4	1.4	2.3	3.5
4 persons	3,378	100	.7	.5	.4	.7	.7	.4	1.0	2.3	1.9
5 persons	1,855	100	.3	.4	.3	.9	1.0	1.2	.8	2.2	2.6
6 persons or more	1,823	100	.8	.5	.7	.7	.6	1.8	1.1	3.3	3.4
Head 65 yr and over	7,590	100	1.2	1.3	2.8	4.4	5.6	6.2	6.3	12.2	10.3
2 persons	6,115	100	1.4	1.5	3.1	5.0	6.2	6.7	7.2	13.5	11.1
3 persons	947	100	.7	.4	1.7	1.3	3.4	3.4	3.4	6.7	7.5
4 persons or more	528	100	1.0	.5	2.0	2.3	2.6	4.5	1.3	8.0	5.3

Age of head and size and type of family—families by total money income in 1972 [1]—Continued

Size of family	Number (thousands)	Percent distribution									Median income	Mean income
		$6,000 to $6,999	$7,000 to $7,999	$8,000 to $8,999	$9,000 to $9,999	$10,000 to $11,999	$12,000 to $14,999	$15,000 to $24,999	$25,000 to $49,999	$50,000 and over		
ALL FAMILIES												
Total	54,373	5.2	5.6	5.4	5.8	11.5	14.6	23.0	6.5	0.8	$11,115	$12,625
Head under 25 yr	4,194	8.9	9.1	8.7	7.0	11.6	10.4	6.7	.4	.1	7,446	7,892
2 persons	2,013	7.8	8.9	8.3	5.9	11.4	11.8	8.2	.5	.1	7,590	8,149
3 persons	1,474	9.4	9.4	9.4	8.5	12.3	8.9	5.0	.3	----	7,399	7,677
4 persons or more	707	10.6	9.1	8.4	7.0	11.0	9.6	6.0	.2	----	7,150	7,609
Head 25 to 44 yr	22,664	4.7	5.2	5.5	6.4	13.4	17.7	26.0	5.4	.6	11,961	12,974
2 persons	3,584	5.7	5.3	5.1	5.5	11.4	15.7	27.2	5.6	.6	11,861	12,782
3 persons	4,503	5.1	6.1	6.0	7.5	13.7	18.2	21.4	3.8	.4	11,081	11,921
4 persons	6,415	4.3	5.0	5.7	6.3	14.4	18.9	27.1	5.2	.6	12,278	13,263
5 persons	4,257	4.0	4.5	4.8	6.4	13.5	18.9	28.0	7.2	.8	12,782	13,974
6 persons or more	3,906	4.7	5.1	5.6	5.9	13.2	15.9	26.1	5.7	.4	11,729	12,800
Head 45 to 64 yr	19,925	4.0	4.8	4.6	5.2	11.2	15.2	28.3	10.4	1.3	13,036	14,849
2 persons	8,220	5.0	6.5	6.0	6.1	12.2	15.0	21.2	6.3	1.0	10,938	12,546
3 persons	4,649	3.4	3.5	4.2	5.4	11.9	16.3	30.7	10.6	1.4	13,653	15,320
4 persons	3,378	2.7	3.3	3.2	3.7	9.8	15.3	36.2	15.6	1.7	15,968	17,620
5 persons	1,855	3.9	3.3	3.7	4.1	10.0	14.9	34.9	14.7	1.0	15,180	16,805
6 persons or more	1,823	3.2	4.7	3.1	4.3	8.9	13.3	33.2	14.8	1.7	14,929	16,907
Head 65 years and over	7,590	7.9	6.9	5.3	4.8	6.3	6.1	8.9	2.9	.6	5,967	8,356
2 persons	6,115	8.4	6.9	5.3	4.3	5.5	5.1	6.2	2.2	.4	5,487	7,454
3 persons	947	5.9	7.7	5.6	8.3	9.1	10.3	18.1	5.5	1.1	9,283	11,646
4 persons or more	528	6.2	5.1	3.8	4.2	10.1	10.5	24.8	6.8	1.1	10,660	12,911

[1] Families as of March 1973.

Source: Current Population Reports: Consumer Income, "Money Income in 1972 of Families and Persons in the United States," Series P-60, No. 90, December 1973, p. 65.

Age and marital and family status—persons 62 years old and over by total money income in 1972, by race [1]

Family status, age, and race	Number (thousands)	Number with income (thousands)	Total money income											Median income	Mean income
			Total	$1 to $499 of loss	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,499	$2,500 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $6,999	$7,000 to $9,999	$10,000 and over	
ALL RACES															
MARRIED COUPLES															
Total, 62 yr and over [1]	8,569	8,533	100	0.3	0.5	1.5	3.2	4.3	5.0	11.8	11.6	17.7	16.8	27.2	$6,323	$8,620
62 to 64 yr	2,256	2,250	100	.3	.2	1.6	2.5	2.8	2.3	4.7	5.4	11.7	18.6	49.8	9,963	11,800
65 to 72 yr	3,837	3,824	100	.4	.8	1.4	3.6	4.2	4.7	10.8	11.6	19.9	18.9	23.7	6,258	8,237
73 years and over	2,476	2,459	100	.1	.5	1.6	3.2	6.1	8.1	19.6	17.2	19.8	11.7	12.1	4,630	6,306
SINGLE, WIDOWED, OR DIVORCED															
Total, 62 yr and over	11,266	10,934	100	1.1	8.4	15.0	16.5	14.3	9.6	11.3	6.6	7.3	5.3	4.6	2,314	3,411
In families	4,091	3,849	100	1.2	14.2	18.6	16.9	12.9	7.7	9.0	5.2	6.5	3.9	3.8	1,970	2,937
Male	832	808	100	.8	7.5	11.5	12.6	15.3	9.8	10.9	8.0	9.0	5.6	9.0	2,620	4,043
62 to 64 yr	121	114	100	.5	.5	11.9	9.4	4.3	1.7	12.9	17.1	7.1	11.7	23.0	4,516	6,524
65 to 72 yr	320	313	100	1.3	7.2	8.5	9.7	17.1	10.6	11.6	5.1	10.8	7.2	10.7	2,787	4,383
73 yr and over	392	381	100	.4	9.9	13.8	15.9	17.0	11.5	9.8	7.7	8.1	2.4	3.5	2,293	3,021
Female	3,259	3,041	100	1.3	16.0	20.5	18.1	12.3	7.2	8.5	4.4	5.8	3.5	2.4	1,835	2,643
62 to 64 yr	432	386	100	.9	12.3	10.6	12.9	9.5	6.9	10.2	11.8	11.6	6.2	7.1	2,778	3,916
65 to 72 yr	1,161	1,087	100	1.5	11.7	18.8	17.1	12.3	8.7	11.2	4.7	6.1	4.8	3.2	2,038	3,008
73 yr and over	1,667	1,568	100	1.2	20.0	24.2	20.1	13.0	6.2	6.3	2.3	4.1	1.8	.8	1,615	2,077
Not in families	7,174	7,085	100	1.1	5.2	13.0	16.3	15.1	10.7	12.5	7.4	7.7	6.1	5.0	2,478	3,668
Male	1,715	1,704	100	1.2	3.6	9.1	11.5	14.3	10.7	15.6	9.4	9.6	8.2	6.7	2,979	4,297
62 to 64 yr	276	274	100	4.5	4.2	7.9	6.8	10.4	5.9	8.8	7.5	10.0	17.7	16.2	4,198	5,586
65 to 72 yr	665	663	100	.2	3.3	7.3	12.8	15.9	10.1	16.4	11.3	9.7	7.6	5.4	3,022	4,315
73 yr and over	774	767	100	.8	3.6	11.1	12.1	14.4	13.0	17.4	8.4	9.5	5.3	4.5	2,809	3,822
Female	5,460	5,381	100	1.0	5.7	14.3	17.8	15.3	10.6	11.5	6.8	7.1	5.4	4.4	2,366	3,469
62 to 64 yr	718	697	100	1.6	4.3	13.0	11.7	7.8	6.1	12.5	9.8	12.9	11.3	9.1	3,448	4,541
65 to 72 yr	2,079	2,051	100	.8	4.9	11.3	15.5	15.7	11.0	13.0	7.5	8.6	6.5	5.3	2,582	3,803
73 yr and over	2,662	2,632	100	1.0	6.8	16.9	21.1	17.0	11.6	10.1	5.6	4.5	2.9	2.5	2,121	2,924

[1] Couples and persons 62 years old and over as of March 1973.

Source: Current Population Reports: Consumer Income, "Money Income in 1972 of Families and Persons in the United States," series P-60, No. 90, December 1973, p. 65.

Among elderly persons not in families, income was substantially lower. For males in the 65 to 72 age category, the 1973 census survey revealed that the median income was $3,022 (less than $60 a week).

Income was also substantially lower for elderly females. Median income, for instance, for women aged 65 to 72 was $2,582 ($50 per week).

Nearly one-half of single women in this age category (48.2) lived on less than $2,500 a year.

And for women in their 70's and above, this relative income position deteriorates further. The median income for women 73 and above was $2,121 (about $40 a week). But even more alarming, more than three out of every five women (62.8 percent) in this age category subsisted on less than $2,500 a year (less than $50 per week).

B. The Impact of Inflation

Throughout 1973 inflation continued to erode the purchasing power of older Americans. To a very large degree, much of the earlier hard won Social Security increases were eaten away by the upward spiral in prices.

By year's end the overall inflationary rate was at an 8.8 percent level, the highest level in more than a quarter of a century (the overall Consumer Price Index increased 9.0 percent from December 1946 to December 1947). But even more important from the standpoint of the elderly: much of the inflationary bite was concentrated in areas that affect them more dramatically. The classic example of course, was the price of food which surged forward at a near record-breaking pace of 20.2 percent. Fuel and utilities increased 11.4 percent, with the bulk of the rise concentrated in the last quarter because of the energy crisis. For the last three months in 1973 fuel and utilities rose at a 7.1 percent level, or 28.4 percent on an annualized basis.

And since September 1972—the effective date of the 20 percent Social Security increase—the overall cost-of-living has increased by 13.4 percent, but food has jumped by 27.5 percent, and certain fuel oils for homes by 72.8 percent during that same period.

The net impact is that the 11 percent Social Security raise was already outdistanced when the elderly received their first checks reflecting this increase.

III. SOCIAL SECURITY LEVELS OF TODAY

Nearly 30 million Social Security beneficiaries will receive a stop-gap 11 percent Social Security increase in 1974 because of Public Law 93-233. Under the new Act, the raise will become effective in two stages. The first step will be an interim 7 percent raise (effective in March 1974) which would be a partial advance payment on a permanent 11 percent increase (effective for June 1974).

This action—together with three other across-the-board raises since December 1969—means that Social Security benefits will be boosted by 68.5 percent in a 4½-year period.

Average monthly Social Security benefits

	December 1969	After 11 percent increase (July 1974)
Retired worker alone	$97	$181
Aged couple	169	310
Aged widow alone	88	177

But because these increases—as well as other reforms for the Social Security program—have been pegged to a low base, the overall dollar impact is substantially less for the typical retired worker than would be a much smaller percentage wage boost for a younger worker. Average monthly benefits for a retired worker living alone will increase by $84 from December 1969 to July 1974, or $1,008 on a yearly basis.[21]

[21] The increase in benefits for a retired worker is actually greater than 68½ percent because average covered earnings under the Social Security program have increased steadily as the maximum taxable wage rises. Second, other improvements besides across-the-board benefit raises in the Social Security program have helped to increase average benefits.

History of percentage increases in Social Security benefit and consumer prices

[In percent]

Act	Date of enactment	Effective date	Across-the-board increases in benefits: Each amendment	Across-the-board increases in benefits: Cumulative	Average increases for all beneficiaries: Each amendment	Average increases for all beneficiaries: Cumulative	Increases in CPI: Between the effective dates	Increases in CPI: Cumulative
1939	Aug. 10, 1939	January 1940						
1950	Aug. 28, 1950	September 1950	77.0	77.0	81.3	81.3	75.5	75.5
1952	July 18, 1952	September 1952	[1] 12.5	99.1	[2] 14.1	106.9	9.3	91.8
1954	Sept. 1, 1954	September 1954	13.0	125.0	13.3	134.3	.5	92.8
1958	Aug. 28, 1958	January 1959	[3] 7.0	140.8	7.7	152.4	7.9	108.0
1965	July 30, 1965	January 1965	[4] 7.0	157.6	7.7	171.9	7.9	124.5
1967	Jan. 2, 1968	February 1968	13.0	191.1	14.2	210.5	9.3	145.4
1969	Dec. 30, 1969	January 1970	15.0	234.8	15.6	258.9	10.8	171.8
1971	Mar. 17, 1971	January 1971	10.0	268.3	10.4	296.2	5.2	185.9
1972	July 1, 1972	September 1972	20.0	342.0	20.7	378.2	5.9	202.8
1973	July 9, 1973 [5]	June 1974	5.9					
1974	Dec. 31, 1973	Mar. 1974	7.0	365.9				
		June 1974	[6] 11.0	379.6				

[1] Greater of 12.5 percent or $5.
[2] 15.2 percent for old-age beneficiaries.
[3] Guarantee of 7 percent or $3.
[4] Guarantee of 7 percent or $4.
[5] The December 1973 amendments substituted a 2-step 11 percent increase for this.
[6] The 11 percent is computed on the basis of the rates in effect prior to March 1974.

On the other hand, average hourly earnings for production and nonsupervisory employees rose by only 28 percent, from $3.13 per hour in December 1969 to $4.02 in December 1973. But for an individual working 40 hours per week for an entire year, this much more modest increase has yielded an additional $1,851—or nearly twice as much annual income when compared with the Social Security beneficiary (although the Social Security beneficiary received aggregate percentage raises at almost 2½ times the percentage wage hikes for a production employee).

Social Security benefits also continue to be well below the BLS Intermediate Budgets. For autumn 1973 the BLS Intermediate Budget [22] for a retired couple is projected to be approximately $5,300 (assuming a 6 percent increase in the overall Consumer Price Index). Yet, average Social Security benefits for a retired couple will only be equivalent to about two-thirds of that modest standard of living, even with the 11 percent raise. Moreover, average annual Social Security payments ($2,172) for a retired worker in 1974 will be only marginally higher than the anticipated poverty threshold for a single elderly person ($2,130).

IV. SOCIAL SECURITY PAYROLL TAX

Major improvements in Social Security in recent years have increased the Social Security payroll tax. From 1969 to 1973, the contribution rate rose from 4.80 percent to 5.85 percent. And the maximum taxable wage base increased from $7,800 in 1969 to $10,800.

At the opening round of hearings on "Future Directions in Social Security," Senator Church emphasized that the committee would pay special attention to the impact of the payroll tax for today's workers. (For further discussion of this subject, see "Developments in Aging: 1972 and January-March 1973", p. 17.)

The payroll tax was also examined closely by the Congress in 1973 during the consideration of legislation to raise Social Security benefit levels. The House Ways and Means Committee report on the 11 percent Social Security increase, for instance, instructed the Advisory Council on Social Security "to review in depth the existing methods of financing Social Security benefits, and both the short-range and the long-range implications as to benefits and taxes as well as to the economy in general." [23]

Under Public Law 93–233 the employee contribution rate will remain the same in 1974 (5.85 percent) as it was in 1973. The maximum taxable wage base, though, will be boosted in 1974 from $12,600 (under Public Law 93–66) to $13,200.

But the vast majority of workers will not have increased payroll taxes. In fact, about 80 percent of all covered workers will pay no more Social Security taxes in 1974 than they did in 1973, primarily because four out of five covered workers are projected in 1974 to have earnings of $10,800 or less (in 1973 the maximum taxable wage base was $10,800).

[22] The BLS Intermediate Budget for autumn 1973 will actually be based upon data collected and analyzed in 1974.
[23] Page 7 of report cited in footnote 16.

In some cases, taxes will actually be decreased because of a 0.1 percent reduction in the contribution rate for self-employed persons. Thus, a self-employed individual earning $10,000 in 1974 will have his Social Security taxes reduced by $10.

For the small proportion of workers with higher payroll taxes, contributions will increase, on the average, by $103 (or approximately $2 per week), when compared with their 1973 taxes. But these individuals will also have their retirement, disability, and survivor protection substantially improved as a result of this legislation.

Despite recent increases in the maximum taxable wage base, it now covers a smaller proportion of all workers' total wages than when the Social Security program went into effect. At that time, the maximum wage base was $3,000. Approximately 95 percent of all workers then had their wages fully covered under Social Security. With a $13,200 wage base in 1974, 87 percent of all covered employees are expected to have their earnings fully covered. In order for 95 percent of all workers to have their wages fully covered in 1974 (the same proportion as when Social Security began), the maximum earnings base would have to be boosted to $19,200.

V. FUTURE DIRECTIONS IN SOCIAL SECURITY

In 1973 the Committee on Aging's Chairman Frank Church launched a study on "Future Directions in Social Security" to examine all important issues related to the Social Security program. (For a discussion of early testimony at the hearings, see "Developments in Aging: 1972 and January–March 1973", pp. 16–20.)

Hearings on Future Directions in Social Security in July 1973 provided further expert testimony on the major issues that must be resolved if the Social Security system is to realize its full potential in assuring economic security for the aged.

In his opening remarks at the July 25 hearing, Senator Church outlined key issues to be explored in depth by the committee:

> **Benefit levels provide only a partial measure of the adequacy and effectiveness of the Social Security system. This committee must concern itself with other issues, such as: What are our national goals for adequacy of retirement income? How high shall the contribution rate or payroll tax be fixed? What more should be done to deal with the high cost of health care for the elderly? What amount of general revenue shall be used for Social Security and Medicare, and for what purpose? How fair is our present Social Security system for members of minority groups? These and other such questions need answers, which is the purpose of the committee's hearings.**[24]

Wilbur J. Cohen, former secretary of HEW and now Dean of the School of Education, University of Michigan, provided a comprehensive analysis of proposals for improving the benefit and tax struc-

[24] "Future Directions in Social Security" hearings before the U.S. Senate Special Committee on Aging, Part 4, July 25, 1973, p. 238.

ture of the present system. He prefaced his specific suggestions by saying:

> Most of the legislation in Social Security in the last 40 years has been reached in Congress by a consensus of the leaders of both political parties. There has been very little on the congressional side of major differences about how to proceed, with one or two exceptions.
>
> I think this kind of consensus which your committee can help arrive at by discussion is what has made Social Security largely nonpolitical, so widely accepted. I shall touch on that in my paper, plus the fact that there has been an incremental improvement in the program. Those two aspects, the incremental improvement of the program and its consensus, have served to make Social Security one of the most widely accepted institutions in American life.[25]

Testimony of the National Retired Teachers Association and the American Association of Retired Persons emphasized the need for providing a retirement benefit that prevents a serious decline in income because of earnings loss. This may now be more feasible since the SSI program has responsibility for providing a basic income floor for all elderly. Said Cyril Brickfield, legislative counsel:

> Divested of the income support function, and hopefully, of the floor of protection philosophy, OASDI can now function primarily as a mechanism to replace an adequate degree of earnings lost as a result of retirement, disability, or death.[26]

With reference to financing, these Associations suggested that some general revenue financing should be considered "to meet additional Social Security revenue needs in the immediate future." [27]

Testimony at the July 1973 hearings reinforced an earlier suggestion that essential improvements in the benefits and financing of Social Security should be accompanied by improved administration.

Several witnesses recommended the establishment of an independent, nonpolitical authority to administer the Social Security program. Among the compelling reasons cited:

- An independent unit would provide continuity of policy and operation.
- It would also provide further protection against subverting the Social Security program for narrow, partisan advantage.
- It would provide a means for removing the transactions of the Social Security trust funds from the unified budget—thus permitting Social Security expenditures to be assessed on their own merits, rather than in terms of their immediate impact upon the overall Federal budget.

Former Secretary Cohen gave this rationale for establishment of an independent commission:

> Social Security is getting so big and so involved and so complex and I have been so concerned with the possibility of political involvement of the executive branch that I have

[25] Pages 240–41 of hearings cited in footnote 24.
[26] Page 288 of hearings cited in footnote 24.
[27] Page 291 of hearings cited in footnote 24.

been thinking more and more that the Congress ought to reestablish an independent board to administer the whole program so as to be sure that no political involvement becomes a factor in the Social Security system.[28]

Mr. Brickfield offered these reasons for justifying separate organizational status:

> The social security field is certainly large, important, and distinctive enough to justify separate organizational status. Even more so would this be true if other, closely related income maintenance programs, such as unemployment compensation and railroad retirement be added to it. However, we believe that a Board could operate effectively within a larger organization if necessary just as it did within the Federal Security Agency and as some other boards and commissions do at the present time. In this case it would be well to spell out, in the law, the full scope of the Board's authority.[29]

Mr. Nelson Cruikshank, President of the National Council of Senior Citizens, stressed that an independent agency could assure continuity in the operations of the Social Security program:

> An independent, nonpolitical agency could assure continuity in both the review of the system's effectiveness and in its day-to-day administration—a continuity that cannot possibly be achieved under the present system when the administering officials are subject to change every few years and the program is reviewed only intermittently by an advisory council or by the Congress.[30]

On November 7, Senator Frank Church announced that the Senate Committee on Aging was considering various alternatives to implement this proposal. He added:

> Throughout its history the social security system has been a model of excellence—in large part because it has been nonpolitical, superbly administered, and free of scandals. These qualities, which have helped to make the social security system such an enormous success, must be given permanence through further organization safeguards.[31]

VI. SUPPLEMENTAL SECURITY INCOME PROGRAM

1973 was a year of preparation for the new Supplemental Security Income program, which will build a floor effective January 1974 under the incomes of the aged, blind, and disabled. Unlike the former adult assistance programs—which were State administered—SSI will be administered by the Social Security Administration.

However, Social Security and SSI will each maintain its own identity. This fundamental concept was given clear expression by

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[28] Page 246 of hearings cited in footnote 24.
[29] Page 398 of hearings cited in footnote 24.
[30] Page 281 of hearings cited in footnote 24.
[31] Congressional Record, November 7, 1973, p. S20074.

the Congress when the SSI program was created. For example, the Senate Finance Committee report said:

> There is, however, some apprehension that administration of the new program and the existing social security programs by a single agency could lead to confusion between the new program and the old-age, survivors and disability insurance program. In this regard, the committee reemphasizes the point made in the House report that while a single agency might administer the programs, there is no intent to merge the new supplemental program with the existing social security program. Each is to maintain its own identity and this uniqueness would be stressed by requiring separate applications and reports for each type of benefit and in particular by issuing separate benefit checks.[32]

A. The Program and Its Impact

For the first 6 months in 1974, the Supplemental Security Income program (SSI) will guarantee to the blind, aged, and disabled a national monthly income of at least $140 for an individual and $210 for a couple. In July 1974 the income standards will increase to $146 and $219, respectively. Persons with no other income will be entitled to the full SSI payment. In addition, the law provides that the first $20 of Social Security or any other earned or unearned income (other than income which is based on need) will not cause a reduction in SSI payments. Thus, most SSI recipients will be assured of a minimum monthly income of at least $160.

Single person getting Social Security benefit of $84.50:	
Basic SSI	$140.00
Countable Social Security	−64.50
SSI pays	$75.50
Social Security	84.50
Total income	$160.00

For earned income over $65, there is a deduction of $1 for every $2 earned. And if there is no retirement income, the earned income exemption becomes $85.

Single person with earned income of $250, no retirement income:	
Earned	$250
	−85
	2÷165
Countable	$82
Basic SSI	$140
Countable earnings	−82
SSI pays	$58
Earned	250
Total income	$308

[32] S. Rept. 92-1230 to accompany H.R. 1 (Social Security Amendments of 1972), 92d Cong., 2d Sess., September 26, 1972, p. 393.

If a recipient does not maintain his own household, his benefit will be reduced by one-third. For persons who receive reimbursable care in Medicaid institutions (public or private hospitals, nursing homes or extended care facilities), their payments will be limited to $25 while they are in such institutions.

B. Problems With the New Program

In 1973 there were nearly 3.3 million persons in the State administered adult welfare programs, aid for the aged, blind, and disabled. But the fiscal 1975 budget projects that the new SSI program will have 4.8 million recipients at the end of 1974, or nearly 50 percent more than for the adult public assistance programs.

Two major factors account for this expected growth. First, the new SSI program establishes more liberal eligibility requirements than existed in many State public assistance programs. Moreover, in States where payment levels to the aged, blind, and disabled exceeded the Federal guarantee levels under the SSI program, Public Law 93-66 requires mandatory supplementation.

Second, many potentially eligible persons for Old Age Assistance never applied because of the demeaning connotations associated with the State and local welfare offices. However, the Social Security Administration does not carry this same stigma. Quite to the contrary, many older Americans—as well as younger Americans—regard the Social Security Administration as a model of excellence to be emulated by other governmental agencies.

1. Administrative

Nonetheless, SSI faced several obstacles as it was about to be launched in January 1974. One of the most formidable concerned administrative difficulties.

Many aged, blind and disabled persons are not yet on the SSI rolls, however efforts are now underway to locate these potentially eligible individuals. One such effort is ALERT, a joint outreach program by the Social Security Administration, the Red Cross, national aging organizations, and the Administration on Aging, which earmarked about $6 million for the program.

Another crucial problem is a need for a sufficiently large staff to administer the new SSI program, as well as provide helpful counsel for a large increase in the number of assistance recipients.

Coordination of SSI with Social Security, Medicaid, public housing, and social services, is also inadequate. Such coordination or interaction between various programs would aid in the effectiveness and productivity of all the programs involved.

Although Federal administration will offer a more simplified program, some of the basic factors which are associated with a need-based program are still existent—such as, asset limitations (individuals may have assets worth no more than $1,500 and couples may have no more than $2,250); a value limit on home property at $25,000; and stringent definitions of unearned income to include such things as gifts, prizes, and awards (financial value) and the value of meals if the recipient is "regularly" fed by his relatives. Most social services received by the

individual, such as meals provided under the Older Americans Act and services under Title XVI, are not considered as in-kind assistance. Up to $60 of "irregularly received income" may be excluded when calculating one's unearned income each quarter. However, many problems are readily apparent, especially considering the definition of income and who will oversee and determine the sources of incomes and their value.

2. Food Stamp Program

Eligibility of SSI recipients to use food stamps has been a major issue since the 1972 Social Security Amendments (Public Law 92–603) created the SSI program.[33] Over the last year, a potential SSI recipient's eligibility to participate in the Food Stamp program has fluctuated. In the original legislation (Public Law 92–603), SSI recipients would not be eligible for food stamps or surplus commodities. This provision was later modified (Public Law 93–86) to allow food stamp benefits for SSI recipients when their SSI including State supplemental payments were less than their public assistance payments plus the bonus value of their food stamps. But, this complex formula would have required a more complicated administrative determination of one's eligibility. Under Public Law 93–233 eligibility for food stamps (for the 6-month period beginning January 1, 1974) will be determined as though Public Law 93–603 and Public Law 93–86 had not been enacted. Thus, eligibility would be determined on the national income and assets limits of the Food Stamp program. Under regulations published January 30, 1974, an SSI recipient's eligibility is determined by the "make-up" of his household. If all of the members of the household are SSI recipients, they would continue to be eligible for food stamps without regard to their income or resources. If the household includes both SSI and AFDC recipients, their eligibility would be automatic without regard to income or resources. SSI recipients who reside in a household with nonpublic assistance recipients must have their eligibility determined on the basis of the national income standards of the food stamp program.

However, if a State has included the bonus value of food stamps in determining its adjusted payment levels (amount of all outside income plus bonus value) for purposes of State supplementation, then the elderly, blind and disabled residing in that State are not eligible. It is anticipated that the Congress will pass further legislation regarding this matter before June 30, 1974, when the provisions in Public Law 93–233 (relating to food stamp eligibility) expire.

3. Medicaid

Another potential problem area is the relationship between the SSI program and Medicaid. Under the legislation which created SSI (Public Law 92–603), States were required to cover all past recipients of cash assistance under the Medicaid program. Moreover, the States have the option of excluding from Medicaid, any person who was not

[33] See Studies in Public Welfare, Paper No. 10, Subcommittee on Fiscal Policy of Joint Economic Committee, October 7, 1973.

eligible for medical assistance under the State's Medicaid plan in 1972 and those who are not considered "medically needy." If the recipient's total income is above the State's standard level for medical assistance, he will not be eligible for Medicaid unless the difference between his total income and the Medicaid eligibility standard is spent on medical care. For example, State X has a medical assistance level of $1,400 and the recipient's total income is $1,600. However, the recipient pays approximately $280 for medical care. Therefore, his total income is reduced to $1,320 which would qualify him for Medicaid in that particular State.

Further changes were made in the law (Public Law 93-233) to provide for Federal matching to be available for Medicaid benefits if the State provides Medicaid coverage for new recipients. This same legislation provided that Medicaid coverage will be mandatory for those persons who receive a mandatory States supplemental payment.

But there are still many difficulties caused by this complex interrelationship because eligibility varies from State to State and from individual to individual. Also, States may choose to forgo paying Medicaid assistance to some "questionable" recipients in order to save State funds. Such inequities will most probably be the impetus for further legislative actions in relation to the SSI-Medicaid relationship.

4. Ancillary Services

Faulty coordination between the federally administered cash payment and the State administered social services has caused considerable problems to the recipients. If an individual is found to have other needs rather than money needs, the recipient is to be referred by SSI personnel to the welfare office. This office then makes the determination of what specific services he needs. Often, SSI personnel who are responsible for referring the recipients are not knowledgeable about the service programs. Consequently, they must refer the individual back to the welfare office which must make the decision about what next service office the recipient must visit.

VII. ADDITIONAL ACTION NEEDED TO END POVERTY AMONG ELDERLY

Social Security increases have helped more than 1 million older Americans to escape from poverty since 1969. But an estimated 3.5 million[31] persons 65 or older were still classified as poor in 1973. In addition, there is a substantial amount of hidden poverty among the elderly. Nearly 1.3 million are not classified as poor (even though their incomes are below the poverty lines) because they live in families with sufficient incomes to raise them above the poverty threshold. The census poverty figures also do not include the institutionalized aged. Approximately 1 million older Americans are in nursing homes

[31] In *Developments in Aging: 1972 and January–March 1973*, it was estimated (p. 14) that 3.1 million persons 65 and older would live in poverty in 1973. This was based upon projections from the Social Security Administration in January 1973. The latest estimate of the poverty among the elderly is 3.5 million, and this is based upon a projection made in January 1974. Official poverty figures on the basis of income data for 1973 will not, however, be collected until March 1974.

and extended care facilities. Of this total, about 500,000 are projected to live in poverty.

Thus, if the hidden poor were also counted, over 5 million elderly persons would have incomes below the poverty thresholds, or nearly one out of every four older Americans.

Estimated 1973 poverty thresholds (weighted basis, rounded to nearest $10)

Unrelated Individual 65 or older	$2,130
2-Person Family, Head 65 or older	2,690

Source: Social Security Administration.

Enactment of the 11 percent Social Security increase—it is estimated—will remove approximately 800,000 Americans from poverty, including 500,000 in the 65-plus age category. Yet even with this improvement, about 3 million older Americans are still expected to live in poverty in 1974.

Assuming a 6 percent increase in the poverty lines for 1974, the thresholds would be at $2,250 (rounded to the nearest $50) for a single aged person and $2,850 for an elderly couple. On a monthly basis, this would be equivalent to approximately $190 (rounded to the nearest $5) for individuals and $240 for couples.

However, the SSI income standards in 1974—$149 for individuals (in July) and $219 for couples—will still be below the poverty indexes. Even with the $20 monthly income disregard, the Federal income standard for elderly individuals ($149 + $20 = $169) will be about $20 under the poverty threshold. And for older Americans with no other source of income, the differential would be more than $40.

FINDINGS AND RECOMMENDATIONS

Despite improvements in Social Security benefits in recent years, older Americans have still not shared in our Nation's increased income to the extent of younger Americans. Fresh, new perspective on this point was brought home very forcefully in a 1973 Census report,[34] which revealed that families with a head 65 and above accounted for 9.6 percent of the Nation's aggregate income in 1952, at a time when they constituted 13 percent of all families. By 1972, the elderly's proportion of family income in the United States had fallen to 9.2 percent of that total, although they represented 14 percent of all families.

The executive branch continues to pursue a half-hearted income strategy without meaningful goals for the Nation's elderly. Its policies fall far short of the objectives articulated at the White House Conference on Aging of 1971. And the overall strategy comes nowhere near the type of response which is needed to deal with the serious retirement income problems facing older Americans.

In fact, since 1969 this Administration has not once taken the initiative in proposing a Social Security increase which would

[34] *Current Population Reports: Consumer Income*, "Money Income in 1972 of Families and Persons in the United States," Series P-60, No. 90, December 1973, p. 6.

keep pace with the rise in the cost-of-living since the last Social Security raise.[35]

The Administration should work with the Congress in a bipartisan manner to come to grips with the vital income problems of the elderly.

In this regard, the committee urges that the following steps be taken as early as possible:

- Because the cost-of-living has risen by more than 11 percent from September 1972 (the effective date of the 20 percent increase) to March 1974 (the effective date of the first stage of the 11 percent raise), corrective action should be taken to assure that the elderly do not suffer a further "inflationary" setback when the automatic escalator provision becomes effective in June 1975.
- An independent, nonpolitical Social Security authority should be established to administer the Social Security program.
- Legislation should be approved to prohibit the mailing of notices with Social Security checks which contain the name, signature, or title of any officer of the United States.
- The income standards for the Supplemental Security Income program should be raised to a level which can, at long last, eliminate poverty for the elderly.
- An automatic cost-of-living adjustment mechanism should be built into the SSI program to protect the low-income elderly, blind, and disabled from inflation.

Moreover, the committee will continue its comprehensive study of "Future Directions in Social Security." Special attention will be devoted to solutions for (1) improving the financing of Social Security, (2) the special problems of elderly minority groups, (3) the development of a sound and comprehensive retirement income strategy for older Americans, (4) equitable treatment for working wives and other women under Social Security, (5) improving the retirement test, and (6) other vital problems.

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[35] Social security increases enacted since 1969:

Act	Date of enactment	Effective date	Amount (percent)	Nixon administration's initial recommendation (percent)	Increase in Consumer Price Index between effective dates of Social Security increases
1969	Dec. 30, 1969	Jan. 1970	15	10	10.8 percent from Feb. 1968 to Jan. 1970.
1971	Mar. 17, 1971	Jan. 1971	10	5	5.2 percent from Jan. 1970 to Jan. 1971.
1972	July 1, 1972	Sept. 1971	20	5	5.9 percent from Jan. 1971 to Sept. 1972.
1974	Dec. 31 1973	March 1974 June 1974	7 [1] 11	10 10	13.4 percent from Sept. 1972 to March 1974.[2]

[1] The 11 percent is computed on the basis of the rates in effect prior to March 1974.

CHAPTER II

PENSION REFORM, PUBLIC RETIREMENT PROGRAMS, AND TAX REFORM

Social Security is the economic mainstay for the vast majority of older Americans. It accounts for over one-half the income for about 54 percent of elderly single persons and 44 of all retired couples. And it is almost the entire support—over 90 percent of total income—for 27 percent of aged single persons and 13 percent of elderly couples.

However, older Americans have a vital stake in other retirement and pension programs, such as Railroad Retirement, civil service annuities, and nonservice-connected disability pensions for elderly veterans. Private sources of retirement income—such as pension coverage—also provide an important and crucial means of support.

I. PENSIONS AND PENSION REFORM

Private pension income may mean the difference between a retirement income which can provide a comfortable standard of living and one that is barely adequate. Yet many workers in private industry are not covered by pension plans and many of those who are participating in such plans will never receive any retirement benefits.

It is estimated that slightly less than half of the full-time workers in private industry are covered by pension plans. Private plan coverage is greatest in industries that are heavily unionized and pay high wages. Plans are not as common in nonunionized low-wage industries such as services and retail trade.

Men are more frequently covered by pensions than women, even when men and women of the same age and service are compared, and white workers are more frequently covered than workers of other races.

Census figures also show that in 1972 only about a third of the covered workers have vested rights in their plans which assures them of a pension at retirement age. As could be expected, workers with long years of tenure were more likely to be vested. However, among workers age 50 or more, only half of the workers in this age group who also had 10 years or more of service had vested rights.[1]

Pension Reform Legislation

The lack of adequate vesting in many plans has, more than any other factor, resulted in a demand for legislation that would assure

[1] For further details on private pension coverage see Walter W. Kolodrubetz and Donald M. Landay, "Coverage and Vesting of Full-Time Employees Under Private Retirement Plans." *Social Security Bulletin,* November 1973, pp. 20–37.

workers of the retirement income that they have been counting on. Many plans require 10, 15, or more years of service with a company before the worker has any vested rights. Many also have specific age and service requirements or state that an employee must be employed by the company at retirement age in order to qualify. One woman testified before this committee that she had worked for a department store for 27 years when the store suddenly decided to close. Although she fulfilled the pension service requirement of 25 years, she was a year and 10 months short of age 65 and received only a small severance pay.[2]

The Subcommittee on Labor of the Senate Committee on Labor and Public Welfare conducted extensive hearings and investigations on private pension plans in the 92nd Congress. One study by the Subcommittee of a sample of plans registered with the U.S. Department of Labor found that a large majority of those who had been covered by the pension plans and then left their jobs forfeited all pension rights. A substantial number of those who lost their pension rights were long service employees.[3]

During 1973, the Senate Finance Committee also held hearings on private pension plan reform and documented again the need for reform. The Committee received testimony from Senator Harrison Williams, Chairman of the Labor and Public Welfare Committee in which he urged immediate enactment of pensions reform legislation based upon the years of study of the need for such legislation. Senator Williams concluded:

> There can be no further justification for further delay in enacting pension reform. Congress has already delayed too long, and American workers have suffered as a result. To let them suffer longer would be unconscionable.[4]

On September 19, 1973, the Senate passed unanimously S. 4, the Retirement Income Security for Employees Act of 1973.

Among the major provisions in the pension legislation:

—All workers would be required to be included in a private pension plan after age 30 or one year of service, whichever occurs later.

—An employee's pension would become 25 percent vested (a nonforfeitable right to a pension) after 5 years of employment. This would increase by 5 percent a year for the next five years and by 10 percent annually for the next five years, until fully vested after 15 years. Workers already in a firm with a pension plan would receive credit for all prior service.

—A Federal insurance fund (administered by a separate corporation within the Department of Labor) would be established to protect workers against loss of benefits because of plan terminations. A worker would be guaranteed $750 a month or half his

[2] U.S. Senate, Special Committee on Aging, "Economics of Aging: Toward a Full Share in Abundance," Hearings, Part 10A—Pension Aspects, Washington, D.C., Feb. 17, 1970, U.S. Govt. Printing Office, 1970. P. 1446.

[3] For details of the study and findings see: U.S. Senate, Subcommittee on Labor, Committee on Labor and Public Welfare, "Preliminary Report of the Private Welfare and Pension Plan Study, 1971," Committee Print, 92d Cong., 2d sess, November 1971, Washington, D.C., U.S. Government Printing Office, 1971, 33 pp.

[4] Testimony of Senator Harrison A. Williams, Jr. before the Subcommittee on Pensions of the Senate Finance Committee, June 12, 1973, as printed in the Congressional Record, June 13, 1973, p. S 11040.

average monthly average wages for his high-five years of earnings, whichever is less.

—The maximum deduction for retirement purposes for self-employed persons would be boosted from 10 percent of earned income with a $2,500 ceiling to 15 percent with a $7,500 limit.

—Employees without pension coverage would be able to deduct 15 percent of their compensation, up to $1,500 a year for retirement purposes.

—Portability (transfer of pension credits) would be available for employees who change jobs, provided that the old and new employers agree.

—Fiduciary standards would be established for all pension and welfare plan administrators and trustees.

House Action

On the House side, both the Education and Labor Committee and the Ways and Means Committee considered pension reform legislation. After jurisdictional problems were resolved, the House passed its pension reform bill, H.R. 2, by an overwhelming majority on February 28, 1974.

The House-passed legislation differs in a number of ways from S. 4. One of the major changes is the vesting provision which gives the employer three choices in the method of vesting for approved pension plans. Another is the lack of a portability provision. These differences will be resolved in a Senate-House conference committee, which will determine the final form of the legislation to be sent to the White House.

II. RAILROAD RETIREMENT: A STATE OF CRISIS

The Railroad Retirement System was created in 1935 to replace company and union pension plans which were then failing because of the great Depression. Like the Social Security program—which was also established in 1935—Railroad Retirement has matured considerably during the past four decades.

During this time the program has moved from a staff retirement system to a family protection plan. Today nearly 1 million individuals receive retirement, survivor, and disability benefits under the Railroad Retirement Act.

A. Why R.R.S. Has Financial Problems

During the first two decades of the 20th century railroad employment accounted for about 4.5 percent of the total labor force. By 1970, it had fallen off to 0.8 percent of all workers. In 1950 1.4 million persons worked for railroads. Today that figure has been whittled down to fewer than 600,000.

At the same time the number of beneficiaries has been growing steadily: from 461,000 in 1950 to almost 1 million today. As a consequence, the ratio of railroad workers has dropped to the point where there are now 0.6 employees per annuitant. On the other hand, the

Social Security program has nearly 3.5 covered workers for every beneficiary,[5] or about six times the ratio of the Railroad Retirement System.

In addition, the railroad industry has been lagging while our national economy has been expanding in the past two decades. From 1950 to 1970, the gross national product grew by about 103 percent in constant dollars, with transportation rising by 73 percent. But the railroad component increased at a more modest rate—only 15 percent.

B. Commission on Railroad Retirement

In 1970 the Congress enacted legislation [6] to establish a Railroad Retirement Commission to study the problems of the Railroad Retirement system and to propose recommendations to make the system actuarially sound. Four major changes were proposed by the Commission in 1972 to achieve this purpose.

The principal recommendation called for the restructuring of the Railroad Retirement program into a two tier system. Tier one would provide a basic benefit payable, the same as under the Social Security program. Tier two would be a completely separate supplementary retirement plan above the basic Social Security tier.

Other recommendations of the Commission included:

- "Legally-vested rights of railroad workers and railroad retirement beneficiaries to benefits based on social-security-covered nonrailroad service should be guaranteed, but future accrual of these dual benefits should be stopped.
- "A firm financial plan should be adopted forthwith to finance the second tier of supplementary benefits through the Railroad Retirement Account on an assured, fully self-supporting basis by contributions from the railroad community through the crisis period of the next 20 to 30 years and then beyond.
- "The benefit formulas and provisions of the system should be restructured and revised to assure that the overall benefits in the future continue to bear a reasonable relationship to wages in a dynamic economy and to make benefits more equitable among the various groups of beneficiaries." [7]

C. Congressional Action in 1973

Historically, Railroad Retirement annuities have been increased by the same percentage amount as Social Security benefits. For example, Social Security payments were raised by 15 percent effective in 1970, 10 percent in 1971, and 20 percent in 1972. Identical annuity increases were enacted for railroad retirees, but on a temporary basis.

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[5] There are now approximately 100 million workers covered under the Social Security program. Nearly 30 million persons receive retirement, survivor, and disability benefits.

[6] Public Law 91-377, approved August 12, 1970.

[7] H. Rept. 93-204 to accompany H.R. 7200, "Railroad Retirement Temporary Benefit Increase Extension," Appendix C, [Excerpt from the Report of the Commission on Railroad Retirement, June 30, 1972, "Major Findings and Principal Recommendations of the Commission on Railroad Retirement"], pp. 39-40, May 11, 1973.

On June 30 these three stop-gap increases were scheduled to expire. But with the passage of H.R. 7200,[8] the three temporary raises—which aggregated almost 52 percent—were continued for 18 months, through December 31, 1974. Additionally, H.R. 7200 called upon labor and management to submit concrete recommendations to the Congress by April 1, 1974, to assure the long-term actuarial soundness of the system, thus making the earlier annuity hikes permanent.

III. VETERANS' PENSION

Elderly veterans, their survivors, and dependents are eligible for monthly pensions if they had wartime service and if their incomes are low. Veterans under age 65 are eligible if they are disabled.[9]

A 10 percent increase in these nonservice-connected pensions was signed into law on December 7, 1973. Recipients of these pensions who also receive Social Security benefits will receive both their 10 percent pension increase and the 11 percent Social Security increase during 1974.

However, if action is not taken, 1975 veteran's benefits will be decreased to the extent that Social Security benefits will increase. The result will be similar to 1972 when as a result of the 20 percent benefit increase, pensions for 1,264,000 retired veterans and widows of veterans were decreased. In addition, 20,000 persons were no longer eligible for pensions because their incomes were raised.

Not in the law was a Senate-passed provision which would have raised the maximum annual income limitations by $400 which represented the approximate average 1972 Social Security increase. The law currently provides that no pension will be paid if a single veteran's income exceeds $2,600 or a married veteran's $3,800.

The problem of coordination of veterans' pensions with Social Security benefits as well as some inconsistencies and inequities which exist in this pension system will be taken up again in 1974.

IV. TAX REFORM AND THE ELDERLY

Most older Americans never fill out Form 1040[10] because their incomes are too low to file a tax return.[11]

However, 8.7 million persons 65 and above had a sufficient amount of taxable income in 1971 (the latest date that complete information is available) to file a Federal income tax return. At that time the elderly filed about 9 percent of all tax returns.

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[8] Public Law 93-69, approved July 10, 1973.

[9] This type of pension is for the elderly and those with nonservice-connected disabilities. Veterans' pensions for service-connected disabilities are paid regardless of income.

[10] A single person 65 or older must file a Federal income tax return for 1973 if his gross income is at least $2,800. A married couple where both spouses are at least 65 file jointly if their gross income is $4,300 or greater. Gross income for tax purposes, however, does not include Social Security benefits, Railroad Retirement annuities, and other tax exempt income.

[11] For more detailed information about the income position of older Americans, see Chapter I (Income and the Advent of SSI), p. 5.

In terms of aggregate numbers:

- Nearly 6.8 million returns (some were joint returns of married couples) were filed by aged persons for taxable year 1971.
- The amount of their income tax paid totaled $7.9 billion.
- About 1 million returns claimed the 15 percent retirement income credit.
- 2.3 million returns were entitled to a refund.

A. Administration's Response

In 1969 a Tax Reform Act [12] was enacted to help close some gaping loopholes in the Internal Revenue Code. Some progress, to be sure, was made in restoring greater equity under our tax laws. However, in 1971 there were still 72 returns with adjusted gross incomes of $200,000 or more, which escaped Federal income tax altogether. And, 1,286 returns with adjusted gross incomes of at least $50,000 paid no tax whatsoever.

These startling revelations helped to provide greater momentum in 1973 for more comprehensive tax reform—as well as tax relief for low- and moderate-income individuals.

On April 30, 1973 Secretary of the Treasury George P. Shultz testified before the House Ways and Means Committee concerning the Administration's proposals for improving the tax code. Several of the Administration's recommendations had potentially far-reaching implications for aged taxpayers.

Among the major proposals:

1. *Special miscellaneous deduction allowance to replace smaller medical expenses.*—One important innovation urged by the Administration would be to establish a new Miscellaneous Deduction Allowance of $500 for taxpayers who itemize their expenses. The MDA would act as a substitute for:

   a. The elimination of smaller medical expenses and casualty losses which do not exceed 5 percent of a taxpayer's adjusted gross income.

   b. The repeal of the gasoline tax deduction for nonbusiness purposes.

   c. The elimination of certain miscellaneous investment and employee business expenses (e.g., union dues, work clothes, home office expenses, safe deposit boxes, and others) which do not exceed $200.

In discussing the individual impact of this provision, the Administration pointed out that the flat $500 MDA would result in greater tax savings for most taxpayers, than itemizing the ap-

[12] Public Law 91–172, approved December 30, 1969.

plicable medical, casualty, and other expenses. But Secretary Shultz also warned:

> Some taxpayers having high medical expenses, casualty losses or extraordinary gasoline or miscellaneous taxes, however may find that the $500 MDA does not adequately compensate them for the changes in the deductibility of these expenses under the proposal.[13]

2. *Age credit.*—The Administration also recommended that the retirement income credit be replaced with an age credit. About 4 out of 10 taxpayers now eligible for the 15 percent credit do not claim it or make errors in computing the amount allowed—in large part because of the complexity of the existing provision and the tax schedule.

The new age credit would be equivalent to $1,500 for a single taxpayer 65 or older and $2,250 for taxpayers filing jointly where both spouses are 65 or older. These fixed dollar amounts would be reduced only by Social Security and Railroad Retirement. The present reduction for earned income for persons under 72 would be abolished.

3. *Property tax credit for the elderly.*—A new property tax credit, up to $500, was also proposed by Secretary Shultz. The credit would come into operation when an individual's real property taxes exceeded 5 percent of his household income. Renters would also be entitled to a credit, subject to the same 5 percent floor and $500 ceiling. For this purpose, 15 percent of rent would constitute property tax. For households with incomes not exceeding $15,000 the credit would be fully available. Thereafter, the maximum credit of $500 would be reduced by 5 percent for household income above $15,000—until the credit would be fully phased out for taxpayers with $25,000 or more in income.

B. Criticism of Administration's Proposals

Members of Congress were, however, quick to note some potential pitfalls in the Administration's tax package.

In his testimony on the Property Tax Relief and Reform Act of 1973,[14] Senator Frank Church pointed out that it would be possible for upper-income older Americans to receive greater tax relief under the Administration's proposal than persons struggling in poverty, although they were paying a proportionately greater share of their incomes for property taxes. He illustrated his point with an example:

> . . . Assume that an aged household with $20,000 in income pays $1,500 in property taxes—7½ percent of the total household income. Under the Administration recommendations, it would be possible for this family to receive a property tax credit of $250.
>
> Now take the case of the elderly homeowner scrimping on $2,000 a year. Assume that his property taxes would equal

[13] "Proposals for Tax Change," Department of the Treasury, April 30, 1973, p. 112.
[14] "Property Tax Relief and Reform Act of 1973," hearings before the Subcommittee on Intergovernmental Relations of the Senate Committee on Government Operations on S. 1255, May 4, 1973, p. 866.

16 percent of his total household income—$320—which would be the national average for persons in this low-income bracket. This individual would be entitled to tax relief amounting to $220 under the Administration's proposal because his refund would be equal to the amount by which his property taxes ($320) exceed 5 percent of his household income ($2,000×5=$100). Yet, this individual living in poverty would receive a property tax refund which would be $30 less than another older American with 10 times the income whose property taxes take a much lower proportion of his budget.[15]

Equitable considerations are also likely to present major obstacles for the Administration.

For example, it will probably be very difficult to justify a property tax credit for an aged taxpayer with $20,000 in income—especially when a younger worker with two children and a $7,500 salary would not be entitled any relief under the Administration's measure.

Criticism was also directed at the Administration's proposed age credit. For example, the new amounts for computing the age credit ($1,500 for single elderly persons and $2,250 for aged couples) would be lower than the existing maximums ($1,524 for individuals and $2,286 for couples) for figuring the present retirement income credit.

And, the existing retirement income credit is already outdated because there have been six[16] Social Security increases, aggregating 104.2 percent, since the retirement income credit was last modernized in 1964.[17] The maximum Social Security benefit after the 11 percent increase for a retired male worker who is 65 in 1974 will be almost $3,650, or nearly 2⅓ times the $1,524 maximum base for computing the retirement income credit for a single person. For an elderly couple (both 65 in 1974) maximum Social Security benefits (after the 11 percent raise) will be almost $5,500, or approximately 2¼ times the $2,286 maximum for the retirement income credit. As a consequence, the 15 percent credit no longer provides comparable tax relief for persons with little or no Social Security benefits (Social Security payments are exempt from Federal income tax).

Finally, the elderly may be the principal losers if the Administration's proposed: (1) Flat $500 miscellaneous deduction, and (2) 5 percent limitation on medical expenses (now medical expenses, as a general rule, are deductible if they exceed 3 percent of a taxpayer's

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[15] Ibid., pp. 866–7.

[16] Social Security increases since 1962:

Effective date:	Percent
January 1965 (Guarantee of 7 percent or $4 per month)	7
February 1968	13
January 1970	15
January 1971	10
September 1972	20
June 1974	11

NOTE.—These increases total 76 percent. But on a compound basis, the 6 raises amount to 104.2 percent.

[17] Most of the features of the present retirement income credit have not been revised since 1962 when the maximum level of income on which the credit is computed was set and when the current earnings limits were established. The 1964 Revenue Act allowed, however, spouses 65 and over who file joint returns to claim a credit on $2,286 of retirement income (one and one-half times the $1,524 maximum base for single persons).

adjusted gross income) should become law. These higher thresholds for the deduction of medical expenditures could pose serious problems for many older Americans—especially since the elderly run a great risk of incurring extraordinary health care costs, even with Medicare's valuable protection.

C. Tax Counseling Assistance

Preparation of a tax return for most persons is a complicated task. But it is frequently much more intricate for older Americans. Upon reaching 65 the taxpayer is oftentimes confronted with an entirely new set of tax rules, usually more complex than the ones during his working years. Widows are perhaps the most frustrated because they are likely to have very little, if any, experience in the preparation of a tax return. But, a pilot project—Tax-Aide for the Elderly—has clearly demonstrated that many of these obstacles can be overcome with appropriate counseling. This program was initiated in 1968, largely at the initiative of the Senate Committee on Aging.

It operates as a cooperative effort between the Internal Revenue Service and membership organizations in the field of aging, such as National Retired Teachers Association/American Association of Retired Persons. Elderly persons are recruited by NRTA–AARP local chapters and are trained by IRS tax experts to assist other senior citizens in preparing their tax returns.

In 1973 the IRS trained 2,500 aged counselors as a part of the Volunteer Income Tax Assistance (VITA) program. These individuals provided guidance and assistance for more than 100,000 taxpayers. Valuable as this assistance is, it still only reaches a relatively small percentage of the potentially large number of older Americans who may need this help.

This was a key reason for Senator Church to introduce the Older Americans Tax Counseling Assistance Act (S. 2868) on January 21, 1974.

Briefly stated, this proposal would provide the financial wherewithal to strengthen the tax counseling program for the elderly by expanding training and technical assistance available for volunteer tax consultants. S. 2868 has been referred to the Senate Finance Committee.

V. FEDERAL CIVIL SERVICE RETIREMENT

Civil Service Commission figures indicate that average retirement age for Federal and postal employees is now 58.

Since 1970, there has been a drop in the average by 2.2 years.

The reasons for this include the following:

1. Earlier retirement permitted under reduction-in-force conditions.
2. Salary raises have provided a better base for the computation of annuities reducing the necessity for working additional years.

3. Cost-of-living increases are automatically provided for retirees.

4. Dissatisfaction and frustration with the job.

During 1973, legislation was enacted into law permitting the voluntary retirement of a Federal employee who has completed 25 years of service, or who is age 50 and has completed 20 years of service, during a period when his or her agency is undergoing a major reduction in force. Annuities are reduced for each month the retiree is under age 55. The Civil Service Commission must make the determination as to when the reduction in force is major and is to see that the retirement is truly voluntary and without coercion.

The effect of this legislation was to legalize actions formerly permitted by the Commission and then withdrawn.[18]

However, the legislation provided for additional control by the Civil Service Commission. Before, agencies could use the special early retirement provisions on their own determination that they were facing a reduction-in-force.

Flexible Preretirement Hours

Senator John Tunney introduced in June 1973, a bill (S. 2022) titled the "Flexible Hours Employment Act" which would provide that 10 percent of all Federal Civil Service jobs would be available on a "flexible hours" basis. This could mean, for example, 4 hour days or less than five days a week.

Those who would be benefitted by this legislation include working wives, students, and men and women reaching retirement age. This could be one solution to the increasing tendency toward early retirement among experienced older Federal workers. Less than full-time work would enable the Government to retain their expertise yet allow the employees to ease into retirement gradually.

Minimum Annuities and Health Benefits

By a vote of 270 to 95 on December 7, the House passed H.R. 9107, which would provide a minimum pension for civil service retirees equal to the minimum Social Security benefit (now $84.50 a month). It would also increase annuities for retirees who had retired before October 20, 1969, by $240 annually for the pensioner and $132 for surviving spouses. A similar bill (S. 1866) passed the Senate on September 11. The differences in the two bills are expected to be resolved in 1974.

The President signed into law on January 31, 1974 (PL 93–246) a bill to increase the Federal contribution for employee and retiree health insurance premiums from 40 to 50 percent in 1974 and to 60 percent in 1975. The bill would also permit employees who (1) retired before January 1, 1960 and (2) received health insurance under the

[18] The Commission withdrew authority for agencies to use these special early retirement provisions usually referred to as "involuntary" because of doubts as to the legality of the authority and criticism of agency actions to coerce older workers to retire early. The Committee's report "Cancelled Careers" was a part of this criticism.

Retired Federal Employees Benefit Act, to elect coverage under the regular Government Employees Health Insurance program. The latter provides more comprehensive coverage.

FINDINGS AND RECOMMENDATIONS

Despite recent legislative victories, millions of older Americans suffer from a retirement income gap which intensifies so many other problems: Health, housing, sufficient fuel to heat their homes, adequate nutrition, and others.

Until this crisis is fully and effectively resolved, a life of dignity and security will continue to be beyond the means of large numbers of elderly persons.

On this point, the White House Conference on Aging was clear and emphatic. Much progress certainly has been made since the 3,400 delegates at the White House Conference called for a retirement income policy worthy of a great Nation. But the challenge ahead is perhaps even greater. Fundamental questions still exist about the "mix" and the role of various income maintenance programs—such as Social Security, Railroad Retirement, veterans' pensions, and others. Further questions also exist about the future directions of these programs and whether bold new concepts should be developed. And this is a major reason the Committee on Aging has initiated its overall study on "Future Directions in Social Security."

Until these long-range questions are effectively resolved, the committee urges that these immediate steps be taken:

- **Enactment of comprehensive pension reforms, with minimum standards for vesting, funding, and reinsurance; strengthened disclosure requirements about the terms of pension plans; and measures to extend pension plan coverage.**
- **Modernization of the retirement income credit to provide elderly teachers, government annuitants, and others with comparable tax relief as Social Security beneficiaries.**
- **Adjustment of income limitations for veterans' pensions to reflect the recently enacted 11 percent Social Security increase.**
- **Prompt action by representatives of labor and management to submit their recommendations at the earliest possible date for placing the railroad retirement program on an actuarially sound basis.**
- **Approval of an Older Americans Tax Counseling Assistance Act.**
- **Enactment of a property tax relief program—financed in part by Federal resources—to protect aged homeowners and tenants from being overwhelmed by extraordinary property taxes and rents. It is also recommended that such programs be linked, where appropriate, with the adoption by the States of reforms in property tax administration.**

CHAPTER III

HEALTH: CONTAINING COSTS AND ASSURING QUALITY

Medicare serves most older Americans well and pays a high proportion of most of their health bills.

And yet during fiscal year 1973, Medicare paid only two-fifths of the average annual total of $1,044 in health care costs of each older person.

Average costs can be misleading,[1] but the fact remains that the 40 percent figure represented a reduction of 2 percent from the previous year.

Reasons for this decline include rising costs and rising Medicare charges. The $84 hospital deductible which went into effect January 1, 1974, is more than double the original $40 deductible.

Consumer reaction to the ever-rising costs of medical care was one of anger and despair at seeing limited incomes and hard-won Social Security raises eroded by the imposition of added Medicare charges and disallowances of Medicare bills.

Administration proposals for even more "cost-sharing" charges for Medicare beneficiaries got nowhere in the Congress in 1973. Yet the President made another attempt at increasing Medicare charges in his Comprehensive Health Insurance Plan introduced in February 1974.

Another approach for reducing costs is professional "peer review" which was authorized by the Social Security Amendments of 1972 and is just beginning to be implemented. This new method of controlling costs in the Medicare program has stirred opposition from the medical community and its effect on the quality of care for patients is still to be seen.

In the following chapter, some of these new developments in the area of costs and quality control in health care for older Americans will be analyzed.

I. THE COST OF MEDICARE TO THE GOVERNMENT

Medicare is the Federal Government's largest health activity and accounts for about 43 percent of Federal health expenditures.

[1] Nelson Cruikshank, President of the National Council of Senior Citizens, said at a hearing (Barriers to Health Care for Older Americans, March 12, 1974, Washington, D.C.): "There is some danger in relying too much on a general average. Those figures include all of those elderly who never meet the deductible amounts, for example, therefore, they get no protection out of Medicare. This greatly reduces the figure in the resulting average. If you take people who have the average stay in the hospital of about 12 days, and a medical bill, and assume for the moment that their doctor accepts assignment, you will find that in the case of the 12-day hospitalization—and a $400 to $500 medical bill—that about 75 percent of this total cost is covered, or even more. So therefore, for the people who have a serious hospital illness, Medicare does a better job, but it doesn't do as good a job as it should. And if we would build on the experience of Medicare—8 years of experience—we could greatly improve it."

It is financed in part by Social Security payroll taxes, in part by those enrolled in the program, and in part by contributions from general revenue funds.

Medicare expenditures are expected to reach $12.1 billion by the end of June 1974 for a rise of $2.5 billion over the preceeding year. Reasons for the increase include the expansion of coverage to disabled persons under age 65; rises in costs; and growth of the aged population.

The American Hospital Association reports that for the year ending September 1973, hospital admissions for patients 65 years and older increased from 6.7 million for the preceding year to 7.1 million, an increase of 5.8 percent. The ratio of 65 and over admissions to total admissions is 22.3 percent, the highest it has been during the 7 years of Medicare.[2]

Since the start of Medicare, expenditures have almost quadrupled, rising from $3.4 billion in fiscal 1967 to $12.1 billion in 1974. This has been financed by a rise in Social Security payroll taxes for health insurance from 0.7 percent of covered wages to 0.9 percent. The maximum amount of wages which are taxed has risen from $6,600 to $13,200. General revenues have risen from $623 million to almost $2 billion.

Escalating medical costs are not the only reason for the increase in program costs but are responsible for a good share of the increase. Medical costs have risen rapidly not only in the Medicare program but throughout the economy. In recent years, they have been one of the most rapidly rising components of the Consumer Price Index.

Between 1967 and September 1973, there was a 38.3 percent rise in medical costs. Of the items included in the medical care component, the most rapidly rising item has been the charge for a semiprivate hospital room. For the same period, it increased 81.8 percent; operating room charges rose 79.2 percent, physicians' fees rose 38.2 percent.

Doctors, as well as hospitals claim that their higher charges are justified by higher costs of providing medical care.

Serious concern over rising Medicare costs has prompted increasing imposition of controls on the Medicare program by the Congress and the administration. The economic stabilization program has also paid particular attention to hospital, doctor, and other provider costs in imposing controls over allowable increases in charges.

II. THE COST OF MEDICARE TO THE CONSUMER

On January 1, 1974, the part A hospital insurance deductible rose from $72 to $84. This means that the payment that beneficiaries must pay for hospitalization before Medicare takes over has more than doubled since the $40 deductible was imposed at the beginning of the program as shown in chart 1.

[2] Hospitals; Journal of the American Hospital Association, 47:24, Dec. 16, 1973, p. 22.

CHART 1.

MEDICAL CHARGES SOAR

	1966	1974	PERCENT INCREASE
HOSPITAL INSURANCE			
DEDUCTIBLE	$40	$84	110%
CO-INSURANCE			
HOSPITAL			
1st-60th DAY	NONE	NONE	—
61st-90th DAY	$10 DAILY	$21 DAILY	110%
LIFETIME RESERVE DAYS	$20	$42	110%
NURSING HOME/EXTENDED CARE			
1st-20th DAY	NONE	NONE	—
21st-100th DAY	$5 DAILY	$10.50 DAILY	110%
MEDICAL INSURANCE			
PREMIUM	$3.00	$6.70*	123⅓%
DEDUCTIBLE	$50.00	$60.00	20%
CO-INSURANCE	20%	20%	—

* Increase scheduled for July 1974.

Coinsurance charges for long hospital and nursing home stays are also linked to the deductible and also went up. The coinsurance for each covered hospital day from the 61st to the 90th day increased from $18 to $21; for each lifetime reserve day from $36 to $42. Coinsurance for care in a skilled nursing facility from the 21st through the 100th day increased from $9 to $10.50.

The monthly premium under part B, supplementary medical insurance is also rising and has also more than doubled since the program began. From a base of $3, the amount has gone to the current $6.30 and is scheduled to go up to $6.70 in July 1974. The cost then will be $80.40 a year for an individual and $160.80 for a couple.

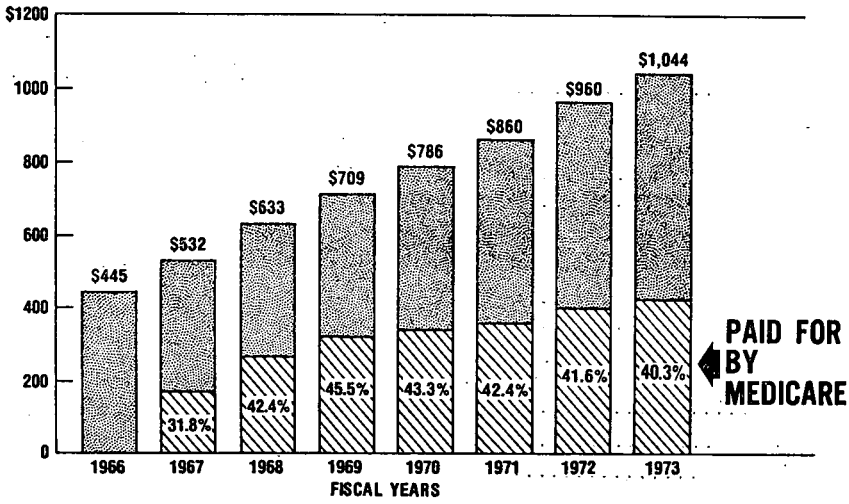
In addition to the premiums, deductibles and coinsurance charges that the beneficiary must pay, Medicare may refuse to pay doctors' charges which are not "reasonable" according to Medicare guidelines. If the physician refuses to accept "assignment," and more than half of them do refuse, the patient must pay the difference between the doctor's bill and what is considered reasonable by the intermediary.

Coverage of Medicare is still far from adequate since it does not cover out-of-hospital drugs, dental work, eyeglasses, and hearing aids. It does not cover preventive medical care and much of the care required by the chronically ill.

In fiscal year 1973, Medicare covered only 40.3 percent of the total health bill of $1,044 per aged person (chart 2).

CHART 2.

MEDICAL CARE BILL PER AGED PERSON AND PROPORTION COVERED BY MEDICARE, FY 1966-1973



Source: Social Security Administration

Per capita out-of-pocket payments for medical care are now actually higher than they were before Medicare began. In fiscal year 1966, they were $234. By 1973, direct payments by the aged averaged $303, or $69 more than the year Medicare became law.

The reaction of older Americans to increasing costs under Medicare included irate charges that "Medicare is for the rich"; it is the "patient who pays"; and as soon as Social Security benefits are raised "it seems to be taken away by some bureaucratic order."

III. EVENTS IN 1973: TUG OF WAR ON COSTS

President Nixon's budget proposals of January 1973 included recommendations for increased cost-sharing by Medicare beneficiaries. They were:

(1) A part A deductible equal to one day's room and board and 10 percent of all subsequent hospital charges.

(2) Raising the part B deductible from $60 to $85 and increasing the coinsurance charges from 20 percent to 25 percent.

It was estimated [3] that, if these recommendations had gone into effect, the elderly and disabled would have had to pay at least $500 million more in hospital and medical care.

Fortunately, the reaction from Medicare beneficiaries and the Congress was immediate and strong. Congressional mail was overwhelm-

[3] "Barriers to Health Care for Older Americans," hearing before the Subcommittee on Health of the Elderly, Special Committee on Aging, Part 1, Washington, D.C., March 5, 1973, p. 78.

ingly against such an increase. And witnesses at several of the committee's hearings on "Barriers to Health Care for Older Americans" found it incredible that the administration could justify such a proposal as a means to reduce "overutilization" of hospital care. It is the doctor, not the patient, who decides when hospitalization is required.

On June 27, the Senate passed a sense of Congress resolution cosponsored by Senators Frank Church and Walter F. Mondale which called upon the Administration to:

(1) Submit a proposal to the Congress to strengthen the Medicare program by including in the coverage out-of-hospital prescription drugs and other appropriate benefits.

(2) Withdraw its earlier recommendations to increase out-of-pocket payments for the aged and disabled under Medicare.

By the end of calendar 1973, the administration had not submitted any proposals to strengthen Medicare but no attempt was made to enact legislation carrying out the budget proposal.

A. Statutory Increase of Medicare Deductible

While the budget proposals were being fended off, the Department of Health, Education, and Welfare announced an increase in the part A Medicare deductible from $72 to $84 as required by law based on last year's increase in hospital costs.

This was countered by a move led by Senator Edmund S. Muskie, to freeze the deductible and related coinsurance rates at the 1973 level. The Medicare deductible freeze amendment was passed by the Senate as a part of H.R. 3153, Social Security Act Amendments of 1973. The raise went into effect, however, when the freeze amendment was stalled in a House-Senate conference committee at the end of the session.

B. Impounded Funds Released

As part of the administration's efforts to cut back on budgeted funds for health programs, certain appropriated funds for programs such as mental health, regional medical centers, construction and health manpower funds were ordered not to be spent. This resulted in the filing of lawsuits by health organizations.

In December 1973, President Nixon announced that he was releasing some $1.5 billion in unspent appropriations for fiscal 1973 which had been challenged by lawsuits. However, only $365.2 million were scheduled to be spent during fiscal 1974 with the rest of the funds to be released later.

C. Cost of Living Council Rulings

Health was one of the three sectors of the economy to be continued under mandatory controls during Phase III of the Economic Stabilization Program which began on January 11, 1973. To administer Phase III, a Cabinet-level Cost of Living Council was appointed and an advisory committee of private citizens was established to advise the Council in the health area.

Since the beginning of the Economic Stabilization Program in November, 1971, hospital costs have been limited generally to 6 percent and physicians' charges to 2.5 percent. While doctors' fees have been rising since then at about the allowed rate, hospital costs have been rising at the rate of 11.6 percent a year even though the increase in each specific service is 6 percent.

Phase IV regulations which were announced in 1973 and which went into effect in January 1974, allow physicians and dentists to raise their fees an average of 4 percent "in recognition of unavoidable increase in their cost of practice." Hospitals are regulated under a new and controversial formula which would focus on the total expense of a patient's hospital stay rather than individual hospital services. Average costs and charges per admission would be allowed to go up 7.5 percent.

The American Hospital Association opposed the new rules and went to court maintaining that the regulations go beyond the price control for they would act as an incentive to reduce the length of the patient's stay.

The American Medical Association also filed suit requesting that the regulations be declared invalid claiming that they arbitrarily discriminate against physicians and hospitals and exceed the statutory authority granted the Cost of Living Council by the Economic Stabilization Act.

Amendments to the Economic Stabilization Act were proposed by the administration to extend authority beyond the April 30, 1974, termination date for mandatory wage and price controls in the health care sector. This would be the only sector with mandatory controls apart from petroleum which is administered under separate authority by the Federal Energy Office.

IV. Focus on Home Health Care

Under the administration's continuing emphasis on cost containment, home health agencies did not prosper despite the fact that care in the home is often less costly than in institutions.

Hearings held in July on home health care by the Subcommittee on Health of the Elderly, chaired by Senator Edmund S. Muskie, dramatized the fact that shortsighted Medicare reimbursement policies were denying needed care to beneficiaries and crippling home health agencies. A working paper[4] on the current status of home health services prepared by the committee's consultant on the subject reported an actual decline in the number of home health agencies.

LEGISLATION

As a result of the hearings and report, a home health legislative package was introduced on November 19 cosponsored by Senators Church and Muskie. One bill (S. 2690) would liberalize the conditions under which home health services could be provided under Medicare, and the other (S. 2695) would stimulate the expansion of

[4] *Home Health Services in the United States: A Working Paper on Current Status.* U.S. Senate Special Committee on Aging, July 1973.

home health agencies and services through a grant program. Grants would also be authorized for training programs for home health personnel.

The bills were referred to the Senate Committee on Finance and the Senate Committee on Labor and Public Welfare. Companion legislation (H.R. 11965 and H.R. 11966) was introduced in the House by Representative Donald M. Fraser and referred to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means.

Home health care was included as a required service for prepaid group health organizations under the Health Maintenance Organization Act of 1973 (see part VI).

It is also included in the language of the major national health insurance bills. In addition, the Senate Committee on Appropriations included in its report [5] on the 1974 appropriation bill the following language:

> The Committee recognizes the necessity to have a comprehensive range of health and social services available to assist older persons to remain independent as long as possible. Therefore, the Committee expects the Commissioner on Aging to work to achieve the integration of social services in this bill with the health services provided through the Medicare and Medicaid programs and to make maximum use of home health service agencies. The Committee suggests that the Commissioner give special consideration to expanding the scope of existing home health service agencies necessary to prevent the premature institutionalization of older persons. There is a great need to help assure essential health and social services to our elderly citizens who need them; make the most effective use of social service funds; and use available resources efficiently with a minimum of duplication. The Committee believes that this action by the Commissioner will be supportive of that goal. There are over 2,300 home health agencies which need to be utilized in local communities to avoid unnecessary duplication and overlap and provide coordinated services.

V. BARRIERS TO HEALTH CARE FOR THE ELDERLY

The need for home health care was a major topic at the series of hearings on "Barriers to Health Care for Older Americans." [6] In addition to that and others already discussed, other major subjects were:

Community health services.—Comprehensive and coordinated health services are needed at the community level which are geared to the special needs of the elderly. This could include the linking of social services such as the nutrition program with medical care.

Consumer participation.—Repeatedly, attention has been called to the lack of accountability and consumer representation under the present system. Consumers should participate in both planning and policy

[5] Departments of Labor and Health, Education, and Welfare, and Related Agencies Appropriation Bill 1974. Senate Committee on Appropriations, October 2, 1973, p. 84.
[6] "Barriers to Health Care for Older Americans," hearings before the Subcommittee on Health of the Elderly, Special Committee on Aging, Parts 5 and 6, Home Health Care, Washington, D.C., July 11–12, 1973.

decisions, so that to the maximum extent possible the system is patient-oriented, rather than run for the convenience of the doctors and health institutions.

Drugs.—The coverage of drugs under Medicare was a recurring topic as was the high cost of drugs. Also mentioned was the over-prescription of drugs.

Medical manpower.—Doctors and other specialists are in short supply in some areas, especially in rural areas and ghettos. In addition, some doctors are refusing to take new patients, particularly Medicare patients. Medical personnel also need special training in how to treat older patients.

Preventive care.—A major gap in coverage in Medicare is health maintenance. Annual physicals and other preventive services are not paid for, a fact that may result in the postponing of seeking medical help until the condition has become acute. Preventive maintenance is one of the most important things that senior citizens need. The emphasis should be on "wellness" and not "sickness."

Transportation.—Difficulty in attaining access to medical care because of a lack of transportation is a major problem, particularly in rural areas and particularly for the disabled. Transportation which is economical and readily available is required.

VI. WHAT NEXT FOR MEDICARE?

As 1973 closed, the Department of Health, Education, and Welfare designated geographic areas for the initial establishment of professional standards review organizations and the American Medical Association passed a resolution to seek repeal of such PSROs.

A. Coming Soon—Peer Review

The 1972 Social Security Amendments directed the establishment of PSRO's to perform peer review of health services under Medicare and Medicaid. A PSRO must be a nonprofit professional organization composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in the area serviced by the organization. The PSRO's will decide:

(1) Whether institutional services are medically necessary and in accordance with professional standards.

(2) Whether patients receive services in settings that are compatible with the level of care required.

(3) Whether elective institutional admissions are medically necessary.

PSRO's will not be involved with questions concerning the reasonableness of charges, costs, or methods of payment but could certainly affect medical costs both for the consumer and the Government by decisions as to the need for medical services such as laboratory tests and hospital admissions.

A spokesman for the anti-PSRO doctor position said he saw the law as leading to "the destruction of humane medical care" and to encroachments of Government bureaucracies on private practice.

It remains to be seen, as PSRO's start to become operational in the coming months, whether this new review system will provide a better quality of care for the elderly under Medicare or Medicaid or whether it will serve as an instrument to further restrict covered services under these programs.

B. Doctors' Fees—More Control by Medicare?

Increases in doctors' fees, and the fact that the elderly are increasingly having to bear these increases, have led to demands for fixed fee schedules. The role of the fiscal intermediaries has also been questioned.

Melvin A. Glasser, director of the Social Security department of the United Automobile Workers Union testified [7] to the adverse effect of the reasonable fee concept of the Medicare program compared to fixed fee schedules as follows:

> Prior to Medicare, our union was able to maintain in most jurisdictions of the country where we have members the continuation of a fee schedule for physician services. There were inequities in the schedule, but basically they operated well. The impact of the billions of Medicare dollars, accompanied by billions of Medicaid dollars, paying on a reasonable and customary basis forced us reluctantly to agree to give up fee schedules and conform with the public program practices. In the very first year of the switch, this represented a 30 percent increase in our insurance costs.

Glasser recommended:

> Adoption of a fee schedule for paying physicians, together with making assignments by physicians mandatory. I am not proposing the introduction of cutrate medicine. Quite the contrary. The adoption of such a schedule could have a major impact on the escalation of Medicare costs.

He also recommended the phasing out of the fiscal agents in favor of direct government supervision of the program.

Nelson Cruikshank, President of the National Council of Senior Citizens, also made a similar recommendation when he issued a statement urging the freeze of the Medicare part A deductible. He said: [8]

> The sensational escalation of medical fees has cost taxpayers and Medicare beneficiaries hundreds of millions of dollars since Medicare began operation. Experience has shown that the Medicare payment intermediaries . . . perform no useful function that the Social Security Administration could not perform much more effectively.

These statements are symptomatic of the dissatisfaction with the current system of payments under Medicare and suggest that there will be continuing pressure for reform.

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[7] "Barriers to Health Care for Older Americans," hearing before the Subcommittee on Health of the Elderly, Special Committee on Aging, Part 2, Washington, D.C., March 6, 1973, p. 131.

[8] National Council of Senior Citizens, press release, November 28, 1973.

C. Health Maintenance Organizations

Health maintenance organizations (HMO's) are prepaid medical group practice plans or foundations which are expected to increase in number and importance as a result of the passage of Public Law 93–222, Health Maintenance Organization Act of 1973. This legislation provides $375 million over a 5-year period for grants and loans for planning, initial development, and initial operating costs.

Two other provisions of the law which are expected to have major impact are:

(1) The preemption of restrictive State laws for HMO's which qualify for assistance.

(2) The requirement that employers must offer their employees the choice of joining an HMO under any company health benefit plan.

There are now about 115 HMO's and this law is expected to stimulate the development of about 300 more. If these expectations are fulfilled, HMO's could become a more viable form of health care under the Medicare program. Currently a relatively small number of Medicare beneficiaries are enrolled in HMO's.

Another factor is the 1972 Social Security Amendments which provided that Medicare services could be received through an HMO on a broader basis than before with reimbursement methods liberalized. These amendments are still awaiting the issuance of regulations by SSA but should be implemented in 1974.

The advantages which are often cited in relation to HMO's are:

They are more efficient compared to solo practitioners.

Because of the prepaid feature, there are built-in incentives to cut down on costs.

Hospital utilization is less.

Emphasis is placed on preventive medicine.

The lack of availability of preventive health care is often cited as one of the major gaps in health care for the elderly. Medicare does not now pay for preventive care provided by HMO's, but the growing number of HMO's could make such care more available and less costly.

VIII. NATIONAL HEALTH INSURANCE PROPOSALS

Of major importance to the future of Medicare (and also Medicaid) is the disposition of the national health insurance proposals pending before the Congress.

A. Comprehensive Health Insurance Proposal (CHIP)

President Nixon sent to the Congress on February 6 the "Comprehensive Health Insurance Act of 1974" (S. 2970). This program would provide a system of health insurance for everyone under either an employee health insurance plan or an assisted health insurance plan. Medicare would be included in the latter but would retain most of its

present administrative structure. Certain benefits would be increased or added, but costs to the consumer would also rise.

COSTS

The following table illustrates the charges that would be made under the Medicare portion of CHIP.

COST-SHARING FOR MEDICARE BENEFICIARIES UNDER COMPREHENSIVE HEALTH INSURANCE PLAN (PER PERSON)

Annual income single	Premium	Deductible		Coinsurance (percent)	Maximum liability (exclusive of premiums)
		Drugs	Other		
I. 0 to $1,749	0	0	0	10	6 percent of income (to $105).
II. $1,750 to $3,499	0	$25	$50	15	9 percent of income (to $315).
III. $3,500 to $5,249	[1] $90	50	100	20	12 percent of income (to $630).
IV. $5,250 to $6,999	90	50	100	20	$750
V. $7,000 plus	90	50	100	20	$750.

[1] Estimated by Administration.

Current Medicare charges can be seen in chart 1, p. 39. The charges under CHIP would be related to income with a maximum charge of $750. Under the administration's proposal, hospital charges for an average hospital stay of 12 days ($110 cost per day) could rise from the current $84 to $342.

BENEFITS

In return for increased cost-sharing, the proposal would provide additional benefits as follows:

(1) Coverage of catastrophic illness in the form of unlimited payment for hospital and medical bills (after a maximum of $750 in charges is paid.)

(2) Coverage of out-of-hospital prescription drugs (deductible of $50).

(3) An improved mental health benefit.

Senator Edmund S. Muskie, chairman of the Subcommittee on Health of the Elderly, held 2 days of hearings on CHIP on March 12 and 13, 1974.[9]

In the opinion of hearing witnesses, the addition of the above benefit package does not justify the increased coinsurance and deductible charges and the introduction of income testing into Medicare. Furthermore, since Medicaid would be abolished except for a residual long-term care benefit, certain benefits such as eyeglasses, hearing aids, and dental care would be lost to low-income Medicaid beneficiaries unless the States choose to continue to provide them without Federal aid.[10]

[9] "Barriers to Health Care for Older Americans," hearings before the Subcommittee on Health of the Elderly, Special Committee on Aging, Parts 8–9, Washington, D.C., March 12–13, 1974.

[10] A statement by Senator Muskie, summarizing issues discussed at the hearing, appears on p. S. 5317, April 5, 1974, Congressional Record.

B. Other Major Proposals

Another new proposal is the "Catastrophic Health Insurance and Medical Assistance Reform Act" (S. 2513) introduced by Senators Long and Ribicoff.

This bill would establish a catastrophic health insurance plan for all and a medical assistance plan for low-income persons to replace Medicaid. The catastrophic section would extend Medicare type benefits to all of the population but only after substantial costs have been paid by the insured—60 days of hospital care and $2,000 in medical expenses. Extended care is limited as in Medicare. Medicare beneficiaries become eligible for benefits only after prolonged hospitalization or medical treatment and after paying coinsurance charges totaling $1,000.

The medical assistance plan would replace the Medicaid program (which varies widely from State to State) with Federal medical assistance to the low-income population including the aged. Older Americans who passed the income test would have their part B Medicare premiums paid as well as their deductibles and coinsurance amounts. The medical assistance program would cover all hospitalization, care in skilled nursing and intermediate care facilities, care in mental health centers, and home health care.

In addition, the bill would provide for coverage of immunizations and pap smears under Medicare.

The Health Security Act (S. 3) introduced by Senator Kennedy and Representative Griffiths, described in last year's summary of legislative action,[11] is still pending. It is the most comprehensive of the major national health insurance proposals. Medicare and Medicaid would be replaced by a national health insurance program for the total population administered by the Department of Health, Education, and Welfare. Virtually all health services would be covered in full and without billing the patient except that there would be certain limitations for nursing home care, dental care, psychiatric care, and prescription drugs.

CONCLUSIONS AND RECOMMENDATIONS

The rising costs to consumers of health care under Medicare have eroded retirement income. Administration proposals to include Medicare under a national health insurance program would not halt this trend but would accelerate it by imposing new cost-sharing charges.

Government efforts to halt escalating medical costs are, of course, necessary, but caution must be used in order not to deny necessary medical services to Medicare beneficiaries or to lower the quality of care under government programs.

In emphasizing cost containment, alternatives to institutional care should be encouraged under Medicare, not discouraged. Enactment of the home health legislation sponsored by Senators

[11] *Developments in Aging: 1972 and January-March 1973.* Special Committee on Aging, May 10, 1973, p. 98.

Church and Muskie would be a major step forward by upgrading the current inadequate Medicare home health benefit and by encouraging the development of home health services.

The new legislation to encourage the establishment of health maintenance organizations (HMO's) will provide more alternatives to the prevailing fee-for-service method of health delivery. Regulations to be issued in 1974 providing for reimbursement of HMO's under Medicare should provide more access to HMO's for Medicare beneficiaries.

Too many gaps still exist in the coverage of Medicare. Drugs, eyeglasses, and hearing aids are still not covered. Dental services, preventive care, and long-term care still lack coverage.

The national health insurance proposals which will be debated and examined in the Congress in the coming months should take into consideration the accomplishments and failings of Medicare. Any plan which is finally adopted must upgrade and not dilute health care for older Americans.

CHAPTER IV

NURSING HOMES: DEFAULT ON STANDARDS

Congress has made it clear in several key enactments within recent years that it wants a stronger Federal presence and higher standards of care in long-term care institutions.

In 1973, however, several disquieting developments raised fundamental questions about the capability or even the willingness of the Department of Health, Education, and Welfare to comply with congressional directives of utmost importance to elderly patients in the Nation's nursing homes.

The chronology of events and reversals:

—In 1971, Congress enacted legislation moving the intermediate care program into Medicaid. A principal reason for doing so was to require precisely written enlightened Federal regulations to achieve genuine improvement in the health care of the infirm aged.

—In 1972, Congress went a step further and mandated the unification of Medicare and Medicaid standards for Skilled Nursing Facilities. Clearly the goal was to *upgrade* standards, not homogenize them, with the weakest ones dominant.

—In 1973, the Department of Health, Education, and Welfare issued preliminary regulations dealing with the intermediate care facilities (ICF's) and the unified regulations for Medicare and Medicaid.

—Almost immediately protests about both sets of regulations arose. In the case of ICF's leaders in long-term care felt that the regulations would encourage widespread "dumping" of patients from higher levels of care to lower levels.

In the case of the unified regulations, a nearly united front of opposition arose to condemn deletions and omissions from the requirements specifically requested by the Congress. For example, Congress had authorized a waiver of 7-day-a-week registered nurse coverage for skilled facilities in rural areas. HEW regulations lowered standards to 5-day-a-week coverage for all skilled nursing facilities. The HEW regulation had the effect of making the entire Nation "a rural area."

—At hearings before this committee's Subcommittee on Long-Term Care, Administration witnesses testified on October 1973 that they had relented on several of the major omissions of greatest concern to the Congress, including retaining the 7-day-a-week registered nurse coverage and requirements for medical direction of long-term care facilities. At the same hearing—at which witnesses had been practically unanimous in condemning regulations announced earlier in the year—the most common complaint was:

The HEW-proposed standards were nebulous to the point of nonexistence. Non-Administration witnesses predicted dire consequences for nursing home patients if such standards were to go into effect. Told about Administration concessions and the apparent decision to offer more realistic standards in the final regulations, they expressed relief.

—Within a few weeks after the hearing, Senator Moss sent to HEW a detailed list of the critical deletions from the congressionally sanctioned existing Medicare standards asking that these specifics be reinstated and commending HEW for its promise to publish its promised concessions in the same edition of the Federal Register in which the final regulations appeared.

In January of 1974, 2 months later, HEW finally returned to the subcommittee the testimony of the October hearing which had been sent to them for whatever minor editing might be necessary for clarity.

Every key commitment made at the hearing for the improvement of standards had either been weakened or expunged completely from the edited testimony, including HEW's promise that the concessions to the committee would appear in the same volume of the Federal Register in which the final regulations appeared.

Subcommittee Chairman Frank E. Moss then wrote to HEW Secretary Caspar Weinberger, asking whether the edited testimony did in fact reflect HEW policy. He was informed that the deletions appeared only because these portions of the prepared statement had not been read at the hearing by Assistant Secretary Edwards and that the Department had no objection to the prepared statement appearing as distributed at the hearing.

However, final regulations appeared only days later. The concessions and commitments to the committee with respect to 7-day-a-week registered nurse coverage, medical direction and other important requirements did not appear in this volume of the Federal Register as promised. The preface to the regulations in the Federal Register promises that these critical standards will be published in proposed form "at a later date".*

The final regulations included only minor accommodations to the objections raised by leaders in the field on long-term care and the subcommittee's request in the form of Senator Moss' detailed list of omissions. The final result was to implement the proposed standards so deplored at the October hearings.

In response, HEW has promised it will offer "at a later date" the commitments it made to the subcommittee. HEW also asserts that much of what was lost will be made up in administrative guidelines.

There is no assurance that HEW will issue the promised standards in the near future. Moreover, there is no assurance that these standards to be issued in proposed form will ever be retained by HEW as part of the final regulations. There is little comfort from

* On May 1, 1974, after this report had gone to press, HEW Secretary Casper Wineberger proposed *preliminary* regulations requiring Skilled Nursing Facilities to have the services of a medical director, registered nurse coverage 7 days a week; a discharge planning program and to observe a list of specified "patients' rights". Whether or not the standards will be made final depends on public comment to be received by HEW no later than June 1, 1974.

guidelines which do not have the force of law, which are only suggestions to the States and to operators.

Upshot

Several important issues arise from the course of events described briefly here, and in greater detail later, in this chapter:

—HEW rulemaking procedures—which had come under criticism in 1973 because there was apparently selective distribution of early drafts of the proposed regulations before they were finally published—are apparently unresponsive even to the most direct expression of congressional concern.

—The limbo which now exists because HEW has promised to promulgate higher standards with respect to a few selected factors "at a later date" could result in a period of marked disintegration of care and the loss of important standards for months to come, if not years.

—HEW recently announced that at least 60 percent of the nursing homes in the United States do not meet the Federal standard. The result of this study and the continuing chronicle of nursing home fires indicates the default in the enforcement of standards by HEW which have been on the books since 1967.

—Despite assurances to Senator Moss that the new standards would not result in arbitrary reclassification of patients, it appears that States have begun to reclassify patients. Pennsylvania reports that as many as 6,000 patients are being transferred to lower-level facilities. Similar trends are reported in many other states—Iowa, Ohio, Alabama, Maryland, Kansas and New Jersey.

—Within recent months the Administration has developed a national health care plan which would rely heavily upon State regulation and implementation. In view of this clear leaning by the Administration, it appears reasonable to ask whether the Administration also believes that it should withdraw from its statutorily imposed responsibility for genuine standard setting in long-term care facilities.

If this is the case, the Administration has a responsibility to seek such action through proposals sent to Congress for consideration and possible enactment.

To take the other course—to undo congressional intent through the regulation-making process—is to change fundamental policy without congressional sanction.

HEW has the responsibility, within the very near future, to tell the Congress why it has defaulted on its responsibility with regard to setting and enforcing standards and improving the quality of care in U.S. nursing homes.

(The full text of this chapter, which follows, presents a highly detailed account of the events, procedures, testimony, and issues discussed in these introductory comments. Only in this way can the full magnitude of HEW's default on standards be fully understood.)

I. CONSEQUENCES OF THE UNIFICATION OF MEDICARE AND MEDICAID STANDARDS FOR SKILLED NURSING FACILITIES

Prior to the enactment of Public Law 92–603, nursing homes under both the Medicare and Medicaid programs were providing "skilled nursing care." Medicaid homes were known as "skilled nursing homes" while Medicare homes were called "extended care facilities" (ECF's). Standards differed greatly. Medicare standards were the most comprehensive and were known as "the conditions for participation in an extended care facility." There was great variation between the two programs as to which medical and nursing arts were compensable as falling within their respective definitions of "skilled nursing care." Medicare, being a Federal program, had one common definition while the Federal-State nature of Medicaid spawned 50 different definitions of entitlement under the label "skilled nursing care."

Public Law 92–603 attempted to deal with this chaotic situation. Section 247 offered a single definition of skilled nursing care describing the scope of coverage Congress intended to be covered. Section 246 sought to unify Medicare and Medicaid standards. Compliance with a single set of standards and one certification procedure would allow nursing homes to participate in both Medicare and Medicaid. In this respect the amendments to Public Law 92–603 were highly desirable. But Congress was even more specific in its intent that standards should be raised by the unification procedure or at the very least that they should not be weakened below their existing levels.

The tragedy of the unified Medicare and Medicaid standards as promulgated by HEW regulations issued in 1973 is, that far from being strengthened, the standards were substantially weakened. Moreover, in the effort to reach a uniform definition of the scope of coverage of skilled nursing care, the most restrictive interpretation possible seems to have been adopted with the result that thousands of individuals will be reclassified as intermediate care patients and transferred to other facilities because of the government's desire to save money. It is the great fear that many patients will die or suffer from such transfers and that they will not be receiving care adequate to their needs.

The interim standards for skilled nursing facilities (SNF's) were announced in the Federal Register on July 12, 1973, following charges that there had been a selective distribution of earlier drafts to the nursing home industry while consumer groups were given only 30 days for comment subsequent to publication. Senior citizen and consumer groups were critical not only of HEW's rulemaking procedure but of the substance of the regulations which they termed "a sellout" or a signficant weakening of the existing standards in violation of congressional intent.

Hearings by the Subcommittee on Long-Term Care

On July 10 and August 3, Senator Frank E. Moss, Chairman of the Subcommittee on Long-Term Care wrote to HEW Secretary Caspar

Weinberger protesting the strong evidence of selective distribution of the standards and for an extension of the comment period. The comment period was extended 30 days which gave consumer representatives time to evaluate the interim standards. The grave misgivings of these organizations about the new standards led them to request Senator Moss to hold hearings on the proposed regulations.

The Subcommittee on Long-Term Care held hearings on the proposed regulations for SNF's on October 10 and 11, 1973. In his opening statement Senator Moss protested the scuttling of existing standards in contravention of congressional intent:

> The reason for these hearings is the enactment last year of Public Law 92–603 and specifically section 246. This section of Public Law 92–603 called for the unification of Medicare and Medicaid standards. Significantly, the statute spells out that the higher standard should be retained in every case. Quoting the language of the Senate Finance Committee's Summary of the Social Security Amendments of 1972:
>
> "A single definition and set of standards (for Medicare and Medicaid nursing homes) is established. A 'skilled nursing facility' is defined as an institution meeting the prior definition of an extended care facility and which also satisfies certain other Medicaid requirements."
>
> What appears to be clear in the minds of many nursing home spokesmen is that the standards have been significantly weakened. The proposed regulations published in the Federal Register on July 12, 1973, delete many of the requirements and specifics which were contained in the previous regulations.[1]

Senator Dick Clark[2] and Senator Pete Domenici[3] echoed these sentiments. Former Congressman David Pryor, testifying for the National Retired Teachers Association/American Association of Retired Persons (AARP–NRTA) agreed, stating that there was nothing in Public Law 92–603 which required a massive revision of the conditions of participation. He quoted the report language from the Senate Finance Committee concerning section 246:

> The committee's amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities.

Mr. Pryor observed that HEW's failure "will bring about the tragic situation where rather than being the better for Public Law 92–603, the patients in skilled nursing facilities will be the worse for it."[4]

Almost all witnesses before the committee shared this view. Senator Moss projected a "sharp drop in the quality of care."[5] Senator Dick Clark called the interim standards a "retreat from good care."[6] Representative Robert Steele, chairman of the House Republican Task

[1] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 21, Washington, D.C., October 10, 1973, p. 2539.
[2] Ibid., p. 2541.
[3] Ibid., p. 2542.
[4] Ibid., p. 2555.
[5] Ibid., p. 2540.
[6] Ibid., p. 2541.

Force on Aging, charged the new standards "failed to guarantee adequate patient care in several major areas." [7] Marilyn Schiff, director of the Ombudsman Program for the National Council for Senior Citizens, urged legislation to repair the deletions HEW made in its interim regulations.[8] The National Council of Health Care Services spokesman, Roger Lipitz, representing several large nursing home chains, also asked that standards be "strengthened, not lowered." [9]

Spokesmen from State health and welfare departments sounded the same themes. For example, George Warner, M.D., director of Bureau of chronic disease and geriatrics, State of New York said:

> In view of these kinds of trends, it seems a very inopportune point in time, indeed, to attempt or to even consider watering down the requirements that are imposed, and were intended by Congress to be imposed, on that level of institution which is next to the hospital level.
>
> The apparent watering down of the nursing standards certainly is to be decried.[10]

Mr. Frederick Traill, chief, division of health facilities and sanitation of the State of Michigan Department of Health:

> The rules we are dealing with are anything but specific, anything but clear, and anything but subject related. I can take what is considered a standard in any one of these three sets of rules, and find it covers anything from apple sauce to peanut butter. Enforcing that standard will be a practical impossibility. So on the one hand we are concerned about the quality of care and quality of life at these homes, and then we see rules come up which essentially defeat the efforts of many agencies, State, and Federal, to improve the quality of life and care in these facilities.[11]

Mr. Marx Leopold, general counsel, Pennsylvania Department of Public Welfare and assistant attorney general:

> I have the strong feeling that the ICF regulations and the skilled nursing home regulations that have been proposed are really, they only have one object, and that is: fiscal considerations.
>
> If you look at these regulations, you will see that they define nursing homes so that they no longer exist, and then provide for standards for intermediate care which are inadequate for most of the people presently in skilled nursing home care, therefore, we avoid the high cost of the skilled nursing home, we have low standards for those same people, and then whatever else you do to save money, you have added a great deal of utilization review.

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[7] Ibid., p. 2545.
[8] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 22, Washington, D.C., October 11, 1973, p. 2757.
[9] Op. cit., Part 21, Washington, D.C., October 10, 1973, p. 2598.
[10] Ibid., p. 2603.
[11] Ibid., p. 2623.

I think if we look at each one of the standards in terms of trying to save the dollar, that is where the decision has been made.[12]

Still other witnesses reinforced these statements. Mr. Don Barry, President of the American Nursing Home Association, stated: "It has become clear to us, Mr. Chairman, that the name of the game in health programs is cost containment." [13]

Dr. Raymond Benack, founder of the American Association of Nursing Home Physicians, said, "The new regulations turn back the hands of time where an institution becomes an institution of death to which we condemn the chronically ill patient." [14]

Elma Griesel, representing Ralph Nader's Retired Professional Action Group:

> As the majority of the other witnesses who have testified, we were astonished, when we reviewed the proposed regulations for skilled nursing home care, to find that HEW had taken several steps backward in its purported goal to upgrade nursing home care.[15]

Marilyn Rose, Washington counsel, National Health Law program said:

> The underlying assumption of these proposed regulations is that specific standards should be deleted, and in their stead generalization be substituted.
>
> * * * * *
>
> We submit that the enforcement of the generalization which HEW has substituted in skilled nursing homes regulations are . . . impossible to enforce. In reality, there are no standards whatsoever.[16]

Edward J. Krill, vice chairman, Committee on Legal Problems of the Elderly, American Bar Association, was asked if he agreed with the assessment that the proposed regulations were vague generalizations, impossible to enforce, and if the proposed regulations would be useful in litigation:

> Mr. KRILL. I find the proposed regulations to be of no assistance whatsoever, and I would have to rely on general principles of law.
>
> I would have to prove negligence, I believe, and would find it very difficult to prove an individual was or was not receiving care to which he was entitled as a beneficiary of the Federal program. The point being I would find it difficult to determine what the intent, what the entitlement was under the Federal program, under the proposed regulations.
>
> I agree with Marilyn Schiff and Marilyn Rose.
>
> Mr. HALAMANDARIS. Is it like saying there are no standards?

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[12] Ibid., p. 2621.
[13] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 22, Washington, D.C., October 11, 1973, p. 2749.
[14] Ibid., pp. 2778, 2788–2791.
[15] Ibid., p. 2770.
[16] Ibid., pp. 2767–2768.

> Mr. KRILL. I would have to agree with judicial opinion to that effect.[17]

In their defense, HEW answered that the standards were merely consolidated and that it was their intent to make the standards more easily understood and to give surveyors some flexibility. One HEW witness referred to the procedure as "removing some of the excessive verbiage." [18]

On October 30, 1973, Senator Frank E. Moss wrote to Secretary Caspar Weinberger summarizing the hearings and urging HEW to reinstitute a long list of significant deletions from the existing standards which HEW dropped in their effort to remove "excessive verbiage." The Senator wrote that "there was near unanimity among the over 30 witnesses who appeared at the Senate hearings that the proposed standards were but vague generalizations—mere ghosts of the previous standards. He restated that this HEW action was contrary to the "clear and obvious congressional intent" to the contrary. He answered HEW's defense of the need for flexibility by stating that the proposed standards "were so flexible as to be unenforceable." Moreover, he charged there was no justification for HEW's "wholesale emasculation of standards."

What follows is an issue by issue examination of the events of the October hearings and HEW's action in response.

HEW's RULEMAKING PROCEDURES

Witnesses at the hearings charged that HEW had made selective distribution of advanced drafts of the nursing home regulations to the nursing home industry. It was further asserted that some of the more substantive regulations contained in earlier drafts had been deleted after receiving pressure from the industry.[19] Spokesmen from State Health Departments charged that they had been given no part in rulemaking procedures.[20] Even spokesmen for the nursing home industry complained about the lack of consistent policies and the inadequate opportunity for consultation and input.[21] Typical of most of these charges is this excerpt from Representative Steele:

> Prior to our July 19 meeting with Ms. Callender, we were aware the drafts of the proposed regulations were available within both the American Medical Association and the nursing home industry. The availability of the drafts was confirmed by the fact that a nursing home industry magazine carried public comment on them before the regulations were ever published. Moreover, some members of the task force, myself included, received detailed written letters on the draft regulations from nursing home operators in early June, prior to their publication in July.
>
> Yet, in contrast, groups representing the aged, the ultimate consumers of nursing home services, were refused all access to

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[17] Ibid., p. 2808.
[18] Ibid., p. 2736.
[19] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 21, Washington, D.C., October 10, 1973, p. 2547.
[20] Ibid., p. 2623.
[21] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 22, Washington, D.C., October 11, 1973, p. 2748.

the draft regulations by HEW. Similarly, the task force staff was refused a draft copy 3 weeks prior to publication.

Thus, the public, aging and consumer groups, and even Members of Congress had 30 days to evaluate and develop their positions on the proposed regulations while health care providers had up to 6 months.[22]

HEW's Response

Dr. Charles Edwards, Assistant Secretary for Health, testified:

As discussed in his letter to you of August 28, the Secretary asked me to undertake a study to determine whether there was in fact a selective distribution of draft skilled nursing facility regulations to various nursing home organizations and a denial of access to consumer organizations who also requested such information.

I would like to take this opportunity to provide you with the findings of this inquiry. *There was in fact a selective distribution of draft skilled nursing facility regulations to various nursing home organizations and a denial of access to other organizations, including consumer groups who requested these documents.* (emphasis added) It must clearly be noted, however, that such distribution was not authorized, encouraged, or condoned by the responsible persons concerned with developing the proposed SNF regulations, and that it was not the intent of the interagency committee or any departmental agency involved in this effort that these unfair practices should occur.

* * * * * * *

The Secretary's office is preparing recommendations with respect to procedures which can be developed to ensure equitable and timely consultation with organizations and individuals outside the Department during the preparation of regulations, and we will furnish this to you as soon as it is completed.[23]

Comment

The rulemaking authority of HEW under Titles 18 and 19 of the Social Security Act should be subject to the public notice and fair comment guarantees of the Administrative Procedures Act and subject as well to judicial review.

Standards Relating To Medical Direction and The Frequency of Physician's Visits

Spokesmen for the American Medical Association,[24] the American Association of Nursing Home Physicians,[25] the American Geriatrics Society [26] as well as other spokesmen for senior citizen groups, testi-

[22] Op. cit., Part 21, Washington, D.C., October 10, 1973, p. 2545.
[23] Op. cit., Part 22, Washington, D.C., October 11, 1973, pp. 2725–2726.
[24] Op. cit., Part 21, Washington, D.C., October 10, 1973, p. 2569.
[25] Op. cit., Part 22, Washington, D.C., October 11, 1973, p. 2778.
[26] Op. cit., Part 21, Washington, D.C., October 10, 1973, p. 2582.

fied in favor of a requirement which had been inserted in earlier SNF drafts requiring medical direction. Each participating nursing home would be required to have either a medical director or an organized medical staff. Arguing for this provision, Dr. J. Raymond Gladue of the American Association of Nursing Home Physicians testified that the care in nursing homes was "either very poor or scandalous".[27] The AMA house of delegates in its 1973 convention resolved medical direction was necessary to help insure the "adequacy and appropriateness of care".

HEW's Response

In the face of unanimous testimony in favor of medical direction in skilled nursing facilities, HEW witnesses announced at the hearing that the Department had changed its position. One such change related to medical direction and another to registered nurse coverage. Testifying on behalf of HEW, Assistant Secretary Edwards said:

> Inasmuch as these requirements were not included in the July 12 proposed regulations, their publication will be under a Notice of Proposed Rulemaking to provide opportunity for public comment, however they will appear in the same issue of the Federal Register in which the final regulations will appear.[28]

HEW also relented on their proposed standard with respect to the frequency of physician's visits. Existing law required patients to be seen at least every 30 days under both Medicare and Medicaid. The proposed standards required this only for the first 90 days, thereafter, at the physician's discretion. At the Senate hearings HEW announced that the new standard would require that patients be seen monthly for 90 days and thereafter at the discretion of the physicians but in no case would a patient go more than 60 days without seeing a physician.[29]

Comment

Apparently the HEW decision on medical direction was sudden. Earlier, the American Medical Association had received a $172,000 grant from HEW to establish 10 seminars across the nation to define the role of a medical director in long-term care facilities. The grant was in anticipation of the promulgation of the requirement contained in early drafts of the regulations. Final regulations announced on January 17, 1974 *do not* contain the requirement for medical direction in either proposed or final form despite HEW's earlier promise to the subcommittee. What is contained is a new promise that such a standard will be issued in proposed form sometime in the future. On a related matter HEW did not reinstate the requirement that physicians see patients every 30 days as requested by the Committee.

That both of these standards are critically needed can be seen from HEW's testimony before the subcommittee:

> Experience in both the Medicare and Medicaid programs has revealed that a major source of deficiencies in long-term

[27] Op. cit., Part 22, Washington, D.C., October 11, 1973, p. 2782.
[28] Ibid., p. 2720.
[29] Ibid., p. 2723.

care facilities has occurred in the provision of physician services, e.g., too infrequent patient visits or outright abandonment, inadequate review of patients' drug regimens, incomplete records, and excessive length of patient stay. Ensuring regularly available physician services is necessary to fulfill Medicare and Medicaid requirements for adequate medical supervision and direct physician care to patients, particularly to patients institutionalized for extremely long periods and in emergencies.[30]

Registered Nurse Coverage and Minimum Staffing Ratios

The American Nurses Association,[31] The National Council of Senior Citizens,[32] the American Association of Homes for the Aged,[33] AARP/NRTA,[34] along with other spokesmen had been unanimous at the hearings in the need for 7-day-a-week registered nurse coverage in skilled nursing facilities. The proposed standards mandated RN coverage only 5-days-a-week, watering down what had been a 7-day-a-week standard. In justification, HEW pointed to Public Law 92–603, section 267 which allowed a waiver of this requirement under certain conditions in rural areas. Senator Moss charged that the effect of HEW's proposed regulations was to make the entire country into "a rural area." Typical of statements before the committee was this comment from Betty Cox, Public Affairs Coordinator, American Occupational Therapy Association.

> Our first concern, and one that is shared by many of our colleagues in other fields, is that the requirement for coverage by a registered nurse during the day tour, 5 days a week, is inadequate to safeguard the health and well-being of patients in skilled nursing facilities.
>
> The incidence of unexpected medical crises of an acute nature is by no means limited to weekdays between the hours of 8 a.m. and 4 p.m.[35]

Witnesses were equally determined that the final regulations make some provision for ratios indicating the minimum numbers of nursing home personnel to patients.[36] Miss Schiff, speaking for the National Council of Senior Citizens said:

> In addition to the requirement for a registered nurse 24 hours a day, 7 days a week, the National Council of Senior Citizens feels strongly that the regulations should specify staffing ratios for the nursing homes. Failure to set staffing ratios is one of the deficiencies of the current regulations that would be perpetuated if the proposed regulations are adopted.

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[30] Ibid., p. 2720.
[31] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 21, Washington, D.C., October 10, 1973, pp. 2577–2580.
[32] Op. cit., Part 22, Washington, D.C., October 11, 1973, p. 2757.
[33] Op. cit., Part 21, Washington, D.C., October 10, 1973, p. 2560.
[34] Ibid., p. 2554.
[35] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 22, Washington, D.C., October 11, 1973, p. 2768.
[36] Op. cit. Part 21, Washington, D.C., October 10, 1973, pp. 2556, 2560, 2578.

Under the proposed regulations, a nursing home regardless of size, need employ only one registered nurse 40 hours a week. During the remaining hours, the home must employ a licensed practical nurse. (If the home has more than 50 beds, the home must also employ a licensed practical nurse during the same shifts as the registered professional nurse.) Beyond this, the proposed regulations have no standards relating to staff size. The only purported standard is that the facility should provide 24 hours nursing service which is sufficient to meet nursing needs. As a result, a 400-bed nursing home could be staffed by one registered nurse 40 hours a week and by one licensed practical nurse on each shift. The number of nurses aides would apparently be left up to the nursing home.[37]

HEW's Response

HEW made its second major concession at the Moss hearings announcing revised regulations with respect to registered nurse coverage.

Dr. Edwards said:

The fundamental issue involved in requiring a registered nurse on duty every day is that there are no 2 days in any given week when nursing care services are less critically needed than on the other 5 days. If the weekend were the 2 days during which a registered nurse was not on duty, the situation could be more critical because other health professionals, especially physicians, are often less available on weekends. Furthermore, nursing personnel less qualified than a registered nurse are not capable of recognizing many sudden and subtle, potentially dangerous changes, that can take place in an ill patient, nor are they prepared to exercise the nursing judgment necessary to respond appropriately in any number of patient crises.[38]

The change from 5-day-a-week RN coverage to 7-day-a-week RN coverage was to be published in proposed form by HEW "in the same issue of the Federal Register in which the final regulations appear." [39] What appeared in the January 17, 1974, Federal Register with the final regulations was the 5-day-a-week RN standard with a note that a proposed standard for 7-day-a-week coverage would be issued some time in the future.

With respect to ratios, HEW flatly refused to issue even the crudest minimum ratios as to numbers of personnel per number of patients. HEW's justification was that ratios are a "false benchmark." "(W)e felt . . . we ought to allow the judgement of the surveyor who is on-site, and who is directly observing the patients in the nursing home, and the type of care they are receiving to make the decision." [40]

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[37] Op. cit., Part 22, Washington, D.C., October 11, 1973, p. 2759.
[38] Ibid., p. 2721.
[39] Ibid., p. 2720.
[40] Ibid., p. 2729.

COMMENT

With respect to registered nurse coverage, the need could not be more clearly stated than in HEW's testimony; nevertheless, the final standards announced January 17 require only 5-day-a-week RN coverage. HEW is in breach of its promise to the committee that a proposed change in this standard would appear in the same issue of the Federal Register. What was issued instead was another promise that 7-day-a-week RN coverage would be mandated in the future.

HEW's refusal to issue minimum ratios means that the only staffing requirements in the current regulations are, 1 RN 5-days-a-week in charge on the day shift and an LPN in charge of each of the other two shifts. This is true whether the home has 50 or 400 patients. The blatant inadequacy of these provisions should be readily apparent. In HEW's words:

> There are no 2 days in any given week when nursing care services are less critical than on the other 5 days.
>
> Nursing personnel less qualified than the RN are not capable of recognizing many sudden and subtle, potentially dangerous changes that take place in an ill patient, nor are they prepared to exercise the nursing judgment necessary to respond appropriately in any number of patient crises.[41]

It is clear that HEW must immediately issue regulations requiring 7-day-a-week RN coverage and minimum staffing ratios such as the 2.25 hours of nursing time per patient mandated in the present medical guidelines.

FIRE SAFETY STANDARDS

Witnesses appearing at the Senate hearings criticised the interim standards for their fire safety provisions. The interim standards mandated that skilled nursing homes comply with the Life Safety Code of the National Fire Protection Association but permit generous waivers. Representative Steele said:

> Last, as a strong advocate of fire safety and the sponsor of legislation to promote fire safety in nursing homes, I was particularly distressed by the fire safety provisions and their final enactment before the termination of the public comment period, effectively stiffling debate on the adequacy of the standards. From long experience in drafting and observing enforcement of fire safety standards, there is no doubt in my mind that these standards, which permit the Secretary to waive portions of the Life Safety Code when (a) the regulations "if rigidly applied would result in unreasonable hardship on skilled nursing facilities, only if such waiver will not adversely affect the health and safety of patients," or (b) a State has fire safety laws which "adequately protect" patients in skilled nursing homes, are inadequate. The regulations

[41] Ibid., pp. 2721–2722.

offer no definition of "unreasonable hardship" in the first situation; and in the second, no definition of "adequately protects." No more specific requirement as to the standards of the State law is given, nor is provision made for cutoff of Federal funds to homes not in compliance with such State laws. What are the guidelines? Where are the teeth in their standards? [42]

Mr. Marx Leopold, general counsel, Pennsylvania Department of Public Welfare and assistant attorney general, complained that Pennsylvania was being singled out by HEW while other States with equally significant violations of fire standards were being overlooked:

> There are those people in and outside of the Department of Health, Education, and Welfare who will tell you that Pennsylvania is one of the few States which is having serious problems with meeting the Life Safety Code requirements.
>
> I do not believe it, and neither should you. I suggest that you take a random sample of nursing home facilities all around the country which are presently certified for medical assistance eligibility and see whether they comply with the Life Safety Code of 1967.
>
> Pennsylvania has been honest enough to indicate when homes do not meet Life Safety Code requirements. For this, the Commonwealth may be penalized.[43]

HEW's Response

Administration witnesses revealed that HEW had developed a training program for surveyors with respect to enforcement of the Life Safety Code which had been attended by 600 surveyors, as of October 1973. It was also noted that HEW had surveyed the more than 7,000 skilled nursing facilities participating in Medicare and Medicaid with respect to fire safety. Moreover, HEW announced the result of testing by the National Bureau of Standards had established that the Steiner Tunnel Test was the most effective test method to determine the flammability of carpet and indicated that this test is employed under existing regulations. The latter provisions were clarified by an HEW witness saying:

> . . . there is both the present and proposed regulations, which do call for the application of the life safety code to all facilities participating in Medicare and Medicaid.
>
> This code does have provisions on floor covering which calls for the application of the tunnel test, where in the judgment of the fire authorities, floor covering does cause a potential hazard in the facility, and of course the application of the tunnel test would require the accepted cutoff point which in the code is 75 for an unsprinklered facility, and 200 for a sprinklered facility.[44]

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[42] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 21, Washington, D.C., October 10, 1973, p. 2546.
[43] Ibid., p. 2617.
[44] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 22, Washington, D.C., October 11, 1973, p. 2744.

With respect to singling out the State of Pennsylvania, Regional Commissioner of HEW, Gorham Black stated:

> Now, to the assertion that there is any persecution on the part of any one State, I can only say this is perhaps a function of numbers, as in the case of region III, because of the vast number of homes that Pennsylvania has as compared with the number of homes in other States within the region. Obviously, our No. 1 attempt is going to be to prevent and has been to prevent a reoccurrence of the tragic incident which occurred in the Washington Hill Home.
>
> We are going to relentlessly see that standards are applied across the board.[45]

COMMENT

The final standards reflect the interim standards, i.e. they still contain generous waiver provisions by which the Life Safety Code provisions can be set aside.

As Congressman Steele noted (above) there are no definitions for such key phrases as "unreasonable hardship" and "adequately protects." At the same time HEW's enforcement of the 1967 fire safety standard has been anything but forthright. In January 1974, seven years after the law was enacted, HEW announced that its investigation indicated 59 percent of the nation's 7,318 Skilled Nursing Homes had serious fire safety violations. Faye G. Abdella, the Director of the Office of Nursing Home Affairs noted she presumed a higher rate of noncompliance among the nation's 8,500 intermediate care facilities. These facts give some support to Mr. Leopold's argument that Pennsylvania was being singled out.[46] It also might be stated that HEW's "No. 1 attempt to prevent a recurrence of the tragic incident which occurred at the Washington Hill Home," was not successful. On December 4, 1973, nine persons died at the Calley Nursing and Rehabilitation Center in Wayne, Pennsylvania, just outside Philadelphia.

Both the State and Federal Governments are to blame for such events but the primary blame is with HEW's standards which are so "flexible" they defy enforcement. Without a stronger Federal presence in either the regulation or the enforcement stages, states will continue to be left to their own devices.

RECLASSIFICATION OF NURSING HOME PATIENTS—SECTION 247

A major focus of the October 1973 Moss hearings was the effect of the uniform definition of skilled nursing care in section 247 of Public Law 92–603. Congressman David Pryor on behalf of AARP/NRTA called it "the seeds of a devastating tragedy." [47] He stated that "if this requirement is applied on a narrow interpretation, then almost all Medicare and Medicaid recipients would be denied skilled nursing facility services. The potential for disaster here is terrifying.

[45] Ibid., p. 2745.
[46] Washington Post, Jan. 16, 1974.
[47] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 21, Washington, D.C., October 10, 1973, p. 2556.

Elaine Brody, director of social services, of the Philadelphia Geriatrics Center predicted "wholesale dumping" of patients into less expensive ICF's. She cited Pennsylvania data showing that about 1 in 15 patients were being classified as skilled patients in Pennsylvania.[48]

Senator Clark provided information about his State of Iowa:

> As I understand it, the new regulations defined skilled nursing care very narrowly that the vast majority of the patients will not fall within that category.
>
> In my own home State, and we double checked these statistics, they seem astounding to me, but out of the 11,000 patients, residents, only 100 will be considered skilled according to our State officials, that is less than 1 percent.[49]

Sister Marilyn Schwab of the American Nurses Association projected that from 75 to 50 percent of the patients currently qualifying for skilled care would not be able to qualify.[50]

George Warner, M.D., of the New York Department of Health also predicted "wholesale reclassification of institutions" and that the "provisions of section 247 as currently understood, have the potential for causing almost sheer chaos in the long-term care field." He added:

> It was mentioned earlier that 700,000 out of 1 million long-term care patients until now were classifiable as needing the skilled nursing facility level of care with the other 300,000 deemed in need of ICF care. Predictions this morning were that section 247 could reclassify the numbers of persons needing skilled nursing or skilled rehabilitation services from 700,000 down to 100,000 and thus cause reclassification of 600,000 nursing home patients to the intermediate care level.
>
> We can envision the problems posed to State surveillance agencies and to the intermediaries of Medicare and Medicaid in trying to tailor their payments to a continuous shifting of population from one category of care to another.[51]

Both Dr. Warner and Elaine Brody said they feared that the application of section 247 would lead to the movement of patients from facility to facility or even from one part of a home to another. Such movement is almost inevitable if there is a large scale reclassification of facilities. Moreover, witnesses testified as to the sharp increases in mortality and morbidity that result when patients are transferred. The phenomenon is most commonly called "transfer shock" or "transplantation shock."

Dr. Warner reminded the committee that section 247 of Public Law 92–603 works in tandem with section 207 which mandates differentials of reimbursement between ICF's and SNF's on a statewide basis. The pressure for saving dollars, therefore, may cause many thousands of individuals to be inappropriately placed in intermediate care facilities which cannot meet their needs

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[48] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 22, Washington, D.C., October 11, 1973, p. 2796.
[49] Ibid., p. 2755.
[50] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 21, Washington, D.C., October 10, 1973, p. 2579.
[51] Ibid., p. 2604.

HEW's Response

In a November 19, 1973 letter to Senator Frank E. Moss, Secretary Caspar Weinberger stated:

> Lastly, you may be assured that I fully share your concern that the Federal Government not create requirements or conditions that would result in arbitrary classification of nursing home patients and needless transfer of patients from one facility to another. The action of the Department in developing regulations to implement section 247 of Public Law 92–603 will be responsive to all reasonable concerns in this regard.

Comment

Immediately following the Senate hearings, Senator Moss instructed that a questionnaire be sent to the executive director of each State's nursing home association to ascertain if wholesale reclassifications were under way and if patients were being likewise reclassified and transferred.

The results of the questionnaire indicate that the reclassification of facilities and patients is underway on a large scale. Specifically, 25 States reported that the reclassification of facilities from higher to lower levels of care is already underway; 23 States reported the reclassification of patients is taking place. While HEW has neither ratified this trend nor admonished the States for such action, it appears that the fears expressed by so many at the Senate hearings are nearing realization. Only aggressive action by HEW can interrupt the current trend.

Other Significant Deletions and Omissions From Existing Standards

With his October 30, 1973, letter to Secretary Weinberger, Senator Moss included a seven-page list of "significant losses from the existing regulations". Senator Moss took HEW at their word that they would reinstate the medical direction and 7-day-a-week requirements and argued strongly for the specifics contained in the previous Conditions of Participation in an Extended Care Facility which HEW deleted. Far from being "excess verbiage," Senator Moss noted: "Without the addition of these specifics the proposed regulations represent an unconscionable retreat from the rudiments of proper care for the elderly." Some of the specific deletions from the previous regulations are listed below. The previous standard is listed first and identified by section number. Following each standard is HEW's response to Senator Moss' suggestion that it be reinstated in the final regulations.

SIGNIFICANT HEW DELETIONS FROM EXISTING STANDARDS

Significant HEW deletions from The Conditions of Participation in an Extended Care Facility (the existing standards) which Senator Moss asked reinstated followed by HEW response:

405:1101 (e) The existing rules refer nursing home operators to Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, or national origin in U.S. nursing homes. This standard was incorporated by reference into the existing Medicare regulations. Deleted from the proposed standards, it should be reinstated.

HEW action: Reincorporated the above in the final regulations as Section 405:1901 (d).

405: 1120 III, Requires written patient care policies with respect to a list of 14 enumerated items [52] from admission to utilization review. These specifics should be reinstated in the final regulations in lieu of substituted language which says only that patient care policies should insure "the patient's medical and psychological needs."

HEW action: Refused to specifically enumerate the 14 subfactor items claiming the above language was sufficient and that further clarification would follow in interpretive guidelines. (Guidelines, unlike regulations, have no force of law.)

405: 1121 A new section (j) should be added incorporating a patient's bill of rights.

***HEW action*: Promised to issue a requirement for a patient's bill of rights with their notice of proposed rulemaking along with the other promised standards for medical direction and 7-day-a-week RN coverage. It is noteworthy that bills calling for a patients bill of rights in SNF's and ICF's have been introduced by Congressman William S. Cohen in the House and by Senator Charles Percy in the Senate.**

405: 1123 Physician's Services. Each skilled nursing facility should have the services of a medical director who agrees to be on call in emergencies, to be legally responsible for the medical care offered by the facility and to spend a specific amount of time in the facility as determined by the size of the home and the number of patients. Sections to be reinstated:

(a) (1) which requires that patient information be obtained by the facility within 48 hours.

HEW action: Reincorporated by HEW.

(b) (1) which requires that medical evaluation be completed within 48 hours of admission unless the patient has been examined within 5 days previously.

HEW action: Reincorporated by HEW.

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[52] These are reviewed at least annually and cover at least the following:
(i) Admission, transfer, and discharge policies, including categories of patients accepted and not accepted by extended care facility.
(ii) Physician services.
(iii) Nursing services.
(iv) Dietary services.
(v) Restorative services.
(vi) Pharmaceutical services.
(vii) Diagnostic services.
(viii) Care of patients in an emergency, during a communicable disease episode, and when critically ill or mentally disturbed.
(ix) Dental services.
(x) Social services.
(xi) Patient activities.
(xii) Clinical records.
(xiii) Transfer agreement.
(xiv) Utilization review.

(b) (3) which requires that attention be given to the foot, sight, speech and hearing problems of the elderly.

HEW action: Deleted by HEW.

(b) (4) which requires stop orders on medications and treatments after *30 days* should be continued. New regulations require stop orders without specifying a time limit.

HEW action: Deleted by HEW.

(b) (6) which requires that a patient should be seen by a physician at least once every 30 days. New rules allow the patient to be seen only every 60 days after an initial 3 months where the patient is to be seen monthly.

HEW action: Committee request for 30-day visits refused.

(b) (7) which requires that a physician attending nursing home patients make arrangements with another physician to cover for him in his absence.

HEW action: Reincorporated by HEW.

(b) (8) which guaranteed, in so far as possible, the right of each patient to select his own physician.

HEW action: Reincorporated by HEW.

(c) (2) which requires that procedures established be followed in an emergency.

HEW action: Reincorporated by HEW.

Comment: The deletion of specific requirements for *30-day* stop orders for medications and treatments is a significant loss along with the requirement that physicians considered the foot, sight, speech and hearing problems of the elderly. In committee experience, this aspect of medical care in nursing homes is the most neglected. There could scarcely be any medical considerations more important to patient well being. HEW's refusal to reinstitute existing standards requiring minimum 30-day visits by physicians is most regrettable. It is a significant denigration of existing standards.

405: 1124 Nursing Services. Subsection (b) should be amended to require that nurses should adhere to the standards established for an organized nursing practice by the American Nurses' Association with particular attention to the need to conduct orientation and in-service training (b) (7), and (c) (2) that the registered nurse, director of nursing service, make daily rounds of all nursing units visiting each patient.

HEW action: To be added in guidelines.

(c) (2) re: daily rounds reinstated.

(d) requirements with respect to charge nurses should be changed to read "in so far as possible charge nurses should be registered nurses and that licensed personnel should be on duty at all times."

HEW action: Incorporated in part—requires licensed personnel on duty at all times.

(d) (4) the requirement that the charge nurse be able to recognize significant changes in patient's condition should be re-entered.

HEW action: Deleted.

(e) (2) the amount of nursing time available for patient care should not be less than 2.25 hours per patient per day.

HEW action: Opposed by HEW.

(e) (3) (iv) the admonition that patients be treated with kindness and respect should be reinstated.

HEW action: Deleted.

(f) Reinstate entire section (1) (2) and (3) which spells out that restorative nursing should begin immediately after discharge from the hospital (2) that nursing personnel should be taught restorative nursing measures to maintain good body alignment; that they should encourage and assist bedfast patients to change positions every two hours night and day to prevent bedsores.

HEW action: Deleted.

(g) (3) reinstate requirement that adaptive self help devices are provided to contribute to patient's independence in eating.

HEW action: Deleted.

(h) (a) Should provide that a nursing care plan accompanies the patient or is obtained by the facility within 24 hours.

HEW action: Deleted.

(i) The entire section on in-service education should be reinstated with the addition of a new factor (6) continuing education should be provided or authorized for the professional staff.

HEW action: Reinstated in section 405.1121 except (6) which was deleted.

405: 1125 Dietary Services. (b) (3) should be reinstated which presently precludes the possibility of dietary staff being assigned outside duties which may interfere with the sanitation or safety of their dietary responsibilities.

HEW action: Reinstituted.

(c) (3) existing language states that persons with communicable disease or open wounds *are not permitted to work.* New language says *should not be permitted to work.* Old language is preferable.

HEW action: Subcommittee suggestions disregarded.

(g) the section relating to the planning of menus should be reinstated. It provides that menus are prepared at least one week in advance, that menus provide for variety in eating, that they are kept on file with records of foods purchased and that enough food supplies are on hand for a one week period.

HEW action: Deleted. Subcommittee referred to Guidelines.

(h) related to the preparation of food should be reinstated in its entirety. It provides that where necessary food should be cut or ground to meet individual needs and that table services are provided for all who can and will eat at a table including those in wheel chairs.

HEW action: Deleted. Subcommittee referred to Guidelines.

405: 1126 Restorative Services. The new regulations should make clear that the medical director, medical and nursing staff are jointly re-

sponsible for restorative therapies along with therapists. Such therapy should be ordered on an individual basis.

HEW action: Reinstated.

405: 1127 Pharmaceutical Services. The new regulations should be changed to state explicitly that unlicensed personnel may not set up or pass medications. Other sections to be reinstated are:

HEW action: Opposed by HEW.

(c) (3) which spells out that medication prescribed to one patient may not be given to another patient.

HEW action: Deleted by HEW.

(c) (5) requiring that medication errors are promptly reported.

HEW action: Deleted.

(c) (6) that up-to-date medical reference texts are made available to personnel.

HEW action: Deleted.

(d) (1) that each patient's medication container clearly indicate the patient's full name, physician's name, the prescription number, the number and strength of the drug, date of issue, expiration date of all time dated drugs, the name, address, and phone number of the pharmacist.

HEW action: Deleted.

(d) (3) that medication is kept in the containers it was received in and that transfer from one container to the next is expressly forbidden.

HEW action: Deleted.

(d) (9) medications having an expiration date are removed promptly and disposed of after such date.

HEW action: Deleted.

Comment: The most significant emasculation of existing standards occurred in the area of the control and distribution of drugs and pharmaceuticals. This is most unfortunate in view of substantial testimony before the subcommittee during the October 1973 hearings of the need for higher standards and greater enforcement. For example, Dr. Allen Kratz, president of the American Society of Consultant Pharmacists, testified that the rate of medications administered in error in long-term care facilities is from 20 to 50 percent. He further estimated that 60 percent of the patients in nursing homes received inadequate pharmaceutical services. HEW in response notes:

"*The detail in the subfactors cited were deleted to be included in interpretive guidelines.*" [53]

405: 1130 Social Services: New regulations should begin, "While social services are not expressly required by law, participating facilities should make an effort to consider emotional and social factors in relation to medical and nursing requirements, and particularly knowledge of the patient's home situation, financial and community resources should be considered with any eye to returning the patient to the community as soon as possible." Sections (a) (1) (2)

[53] "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 22, Washington, D.C., October 11, 1973, p. 2800.

and (5) should be reinstated. (c) should be reinstated which mandates in-service training and orientation for staff directed toward understanding the emotional problems and the social needs of sick infirm or aged persons.

HEW action: The committee request was disregarded and the above deletions were implemented in final regulations.

405.1131 Patient Activities, Sections. (d) (3), (4), (5), (6) and (7) should be reinstated, they provide:

(3) patients are encouraged but not forced to participate in activities.

(4) patients who are unable to attend religious services are assisted to do so.

(5) patient's requests to see their clergymen are honored and space is provided for privacy during visits.

(6) visiting hours are flexible and posted to encourage visiting by friends and relatives.

(7) the facility make available a variety of supplies and equipment to satisfy individual needs including books, newspapers, magazines, radio and television, stationery, et cetera.

HEW action: All the specifics above were deleted despite the committee's request that they be reinstated. HEW provides the justification that the same factors will be included in administrative *guidelines* which unlike regulations, do not have the force of law.

A final comment: Senator Percy's question to HEW witnesses stands as a final comment to HEW's deletions. He received the agreement from witnesses that their first priority was higher quality patient care and asked: In what way do the omissions that have been made contribute to the objective? [54] The obvious answer is that HEW is in default of its responsibility to protect the rights and insure the proper care for the infirm elderly. The omissions cannot but contribute to a reduced quality of care.

II. FINAL STANDARDS FOR INTERMEDIATE CARE FACILITIES: HEW'S DEFAULT ON STANDARDS, PART TWO

Public Law 92–223 authorized the participation of intermediate care facilities (ICF's) in the Medicaid program, creating a second, less intensive level of care. ICF's provide care and services beyond board and room and short of skilled nursing care. Preliminary standards for ICF's were announced by HEW on March 5, 1973. These standards, while weak in some areas, were considered acceptable by most advocates of the elderly. Turning aside congressional requests for the improvement and strengthening of these standards, HEW inexplicably weakened the proposed standards. The final ICF standards announced January 17, 1974 offer tenuous and uncertain protection for the thousands of individuals to be housed in these facilities.

[54] Ibid., p. 2736.

A. Changes Between the Proposed and the Final Regulations: An Overview

The committee's last annual report, *Developments in Aging: 1972 and January-March 1973*, provides full details on the origin of the intermediate care concept beginning with its enactment in 1967 as part of Public Law 90–248 and ending with an analysis of the proposed March 5, 1973 regulations. The committee report underscores the primary purpose of Public Law 92–223 which was first to move ICF's into the Medicaid program and require uniform Federal regulations. The proposed standards in implementation of this law, while far from optimum, were considered acceptable by most spokesmen for the elderly. The committee report, for example, applauds HEW's efforts while suggesting certain substantive improvements in the regulations.

Far from making substantive improvements, HEW greatly diluted the proposed standards to the degree that many spokesmen such as Subcommittee on Long-Term Care Chairman, Senator Frank E. Moss, have grave concerns for the safety of ICF patients.

The preface to the regulations as announced in the Federal Register of January 17, 1974, contains a long list of deletions with HEW's justification for the action.[55] Among these are the following:

1. *The proposed standards are too detailed to permit facilities requisite flexibility.* Accordingly, requirements for administrative management, resident records, rehabilitative and restorative services, social services, activities programming, dietary services, health services, and pharmacy services have been shortened and procedural details eliminated.

2. *Professional resources to meet staffing and consultant requirements are scarce or unavailable in many areas.* Consultants in the areas of social services, activities programming, and meal services have been eliminated. The RN and pharmacy consultants are retained. With the exception of the licensed practical nurse, the requirement that professional individuals on the ICF staff be designated to supervise the various resident services has been deleted. The functions, stated in terms of objectives, have been retained. The professional staff rendering or supervising physical therapy, occupational therapy, speech and audiology services, social services and psychological services in an institution for the mentally retarded are no longer required to have specialized training in mental retardation or one year of experience in treating the mentally retarded. Master's degrees are no longer required for social workers and educators who are Qualified Mental Retardation Professionals. Specific staff-to-resident

[55] Federal Register, Jan. 17, 1974, Vol. 39, No. 12, Pt. II, pp. 2219–2237, "Intermediate Care Facility Regulations".

ratios in institutions for the mentally retarded have been deferred for 3 years.

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4. *Environment and sanitation standards are overly detailed and impose an unnecessary burden on the facility.* Physical standards have been revised to eliminate reference to special requirements for laundry facilities, food preparation areas, fire inspection reports on file, elevators, basic service areas for major subdivisions, one dayroom per floor, maintenance staff, indoor and outdoor recreational areas and access to outside exposure and corridors. Bedroom requirements are stated in terms of minimum square footage, with variations permitted by the survey agency under certain conditions. A resident call system has been added in intermediate care facilities other than institutions for the mentally retarded. Specific numbers of toilets and bathing facilities per resident in institutions for the mentally retarded have been deleted. Waiver authority for environment and sanitation standards has been modified to conform with skilled nursing facility standards.

Other changes from the proposed regulations include the deletion of a separate set of standards with respect to individuals who are mentally retarded. A proposed set of regulations with respect to mental retardation and related conditions will be effective in 3 years. Psychological evaluations upon admission and periodic reevaluations of the patient's conditions were dropped as too frequent. New language calls for psychological evaluations "only where appropriate". Social re-evaluations as part of the active treatment requirement are now required only on an annual basis. While new language has been added to insure that individuals are transferred to hospitals or skilled nursing facilities if their condition changes, the requirement for a transfer agreement between the ICF and the SNF has been deleted and waiver authority given State surveyors to allow ICF's to participate in Medicaid without transfer agreements with a hospital.

Comment

All in all, the final ICF regulations poorly serve the interests of the nursing home patients. They reflect the same pattern as the skilled nursing facility regulations in that virtually all the specifics were deleted in the name of "flexibility." The proposed standards (March 5, 1973) were hardly too detailed; their very lack of specificity, particularly with respect to personnel requirements, caused them to be criticised by senior citizen representatives. The final standards (Jan. 17, 1974) are clearly *too* flexible, so much so that many argue that there is little left of the March 1973 standards. This lack of specificity (or excess flexibility) makes the standards impossible to enforce. Unhappily, the result cannot but be a deterioration in the quality of care.

This is especially true of the personnel standards which were weak in the proposed standards and even more anemic in the final regula-

tions. There is no evidence of personnel shortages that will justify the downgrading of this standard. If the motive is cost containment, the move will prove to be "false economy" in that individuals needing care will debilitate in and require transfer to the more expensive skilled nursing facility or the general hospital.

B. A Close-Up of the Final ICF Regulations

The inadequacy of the final regulations with respect to intermediate care facilities is readily apparent. Examination reveals example after example where undefined generalization has been substituted for a specific standard. Some standards are stated in the alternative which really means the lower of the two options becomes the standard. Still closer analysis reveals that many apparently solid standards disappear in the permissible waivers and exceptions.

An analysis of six standards appears below. Each standard is stated in detail and followed thereafter by comment.

1. Nursing Personnel Standards

An ICF is required to have either a registered nurse (RN) or a licensed practical nurse (LPN) in charge full time 7-days-a-week. If the chief nursing officer is an LPN then the facility must supplement with 4 hours weekly consultation with an RN. *Except* in an institution for the mentally retarded or those with related conditions having less than 15 beds where a physician certifies there is no need for a professional nurse. In such case the facility need only make arrangements with a nurse to appear as needed. With respect to other staff members the standards suggest "sufficient numbers of staff to carry out policies and responsibilities." No ratios or minimum numbers of staff to patients are required. Even those ratios previously promulgated with respect to the mentally retarded who are aggressive, assaultive, or security risks have been deleted and postponed for 3 years.

Comment

The standard is blatantly inadequate. It requires only one LPN 7 days a week, 8 hours a day. The other two shifts, evening and afternoon, will likely be without licensed personnel—certainly none is required. If the LPN is the highest ranking nursing officer in the facility, she must have 4 hours weekly consultation with an RN, but this does not take away from the fact that in most facilities licensed coverage is required only 56 hours out of the 168-hour week. No minimum ratios are required therefore. This conclusion applies regardless of whether the facility has 20 or 190 patients. The administration and control of drugs will be a particular problem since present data suggest a substantial rate of drugs administered in error in U.S. long-term care facilities in general. Without licensed personnel on duty at all times, the problem may be magnified since many of the patients in tomorrow's ICF will be using large amounts of drugs.

It is true that HEW has required that unlicensed personnel passing medication must complete State training programs (duration and curriculum unspecified) before being allowed to administer drugs. Nevertheless, Assistant Secretary Edwards put this issue in perspec-

tive in his October 1973 appearance before the subcommittee when he said:

"(N)ursing personnel less qualified than the registered nurse are not capable of recognizing many sudden and subtle, potentially dangerous changes that can take place in an ill patient, nor are they prepared to exercise the nursing judgment necessary to respond appropriately in any number of patient crises."

By the same token, HEW's regulations require consultation with a licensed pharmacist to insure proper drug administration and storage procedures. Unfortunately, such consultation is not required at specific intervals.

2. Nutrition and Food Management

With respect to nutrition, a staff member "suited by training or experience in food management or nutrition" is required. However, if the facility accepts patients that need medically prescribed special diets then the menus must be reviewed by a professional dietitian or the attending physician and the facility must (in a manner unspecified) provide supervision for the preparation and serving of these meals to patients.

Comment

Under these standards almost anyone can qualify as a nutritionist or a food manager in an ICF. The standards lack any suggestion as to the methods to be employed by the home to supervise the preparation and serving of special medically prescribed diets. The quality of food in ICF's will most likely suffer as a consequence of these regulations.

3. Social Services

Social services are required "as needed for the preservation of the resident's physical and mental health." However, it is required that these important services be provided only by a "staff member suited by training or experience".

Comment

This is another area where the proposed regulations were sharply curtailed to the detriment of the ICF patients, most of whom will be more ambulatory than SNF patients, in some cases younger than 65 and having greater need, not less need, for qualified social services.

4. Physician's Services

Physicians must see patients in ICF's every 60 days "unless justified otherwise." *Except*, in the case of the mentally retarded and those with related conditions wherein it is required they have annual physical and dental care.

Comment

The standard is inadequate on its face. Some intermediate care patients will have a need to see a physician much more often. While it may appear that the "unless justified otherwise" language may take care of this contingency, the language without further definition operates as a limitation. It is not clear how physicians would justify additional visits or even if they are allowed. Another interpretation

of these words amounts to a waiver of the 60-visit requirement. By this analysis, a physician can see patients less frequently than every 60 days. It is not clear how a physician would "justify" such procedure, nor is there any time limit as to what length of time a physician can certify that an ICF patient does not need visits every 60 days.

5. Patient Activities

A therapeutic activities program is required "to encourage restorative self-help and maintenance." Such program is to be conducted by "a staff member qualified by training or experience."

Comment

The regulations themselves underline the importance of a therapeutic activities program and yet the requirement is that any staff member qualified by training or experience may supervise such activities. The standard is vague, uncertain, and inadequate.

6. Physical Environment

Five physical environment standards are set forth below; each followed by commentary.

A. Toilet Facilities

"Each room be equipped with or conveniently located near adequate toilet facilities."

Comment

The standard is vague and open to any interpretation. There are no indications as to what the words "conveniently located near" mean. Forthright standards would include minimum numbers of toilet facilities per number of patients and specifics as to their location and convenience.

B. Bathing Facilities

"Bathing facilities appropriate in size and number to meet the needs of residents."

Comment

The standard gives no indication as to the number and kind of bathing facilities that are required.

C. The Removal of Architectural Barriers—Facilitating the Use of ICF's by the Physically Handicapped and Disabled

"All necessary accommodations are to be made to meet the needs of persons with semi-ambulatory disabilities"—that is, ICF must be made accessible to the physically handicapped. "*Except*, that a State may waive in existing buildings for such periods as it deems appropriate if this standard when rigidly applied would result in unreasonable hardship to the facility but only if the waiver will not adversely effect the health and safety of residents."

Comment

The standard purports to remove architectural barriers and make them accessible to the physically handicapped, however, it soon vanishes in a waiver that allows the States to exempt existing buildings from this requirement, *for such periods as they deem appropriate*

(perhaps one day or forever) if this standard in being rigidly enforced would result in unreasonable hardship to the facility (the term unreasonable hardship is left undefined) upon a finding that the waiver will not adversely effect the health and safety of patients. These terms as well are not defined. What is left is enough room for each State to enforce or not enforce the ICF standards as they so wish.

D. Minimum Area Requirements, Per Patient Per Bed

The standard requires that not more than 4 individuals be housed in one room and that each have a minimum of 80 square feet per bed. *Except* that the survey agency may waive existing buildings for such periods as it deems appropriate if the standard being rigidly enforced would result in unreasonable hardship to the facility but only if such waiver will not adversely effect the health and safety of residents.

Except again, with respect to the mentally retarded and those with related conditions wherein the standard requires not more than 12 individuals in any given room and a minimum of 80 square feet per bed. *Except* that the State may waive in existing buildings for such periods as it deems appropriate, if such provisions which if rigidly enforced would result in unreasonable hardship to the facility but only if the waiver is in the particular needs of residents and will not adversely affect their health and safety.

Comment

The same terminology is employed once again so that the substance of an effective regulation evaporates in exceptions, waivers and generalizations. The real damage is that the Federal government through HEW is content to allow the States to waive this and other standards as long as they like (for such periods as it deems appropriate). Waivers from existing standards, if they exist at all, must be time-limited and specific. The terms "unreasonable hardship" and "adversely affects the health and safety of patients" are anything but specific.

E. Fire Safety Standards—Compliance With the Life Safety Code of the National Fire Protection Association (21st Edition)

ICF's must comply with the Life Safety Code of the National Fire Protection Association. *Exception No. 1.* In the case of small homes with 15 beds or less housing the mentally retarded or those with related conditions. As to these facilities the States may apply the residential occupancy sections of the Life Safety Code rather than the institutional occupancy sections upon a finding by the State that the individuals in such facilities are capable of following direction in an emergency and are ambulatory.

Exception No. 2, States may waive the application of the Life Safety Code entirely, or separate provisions of it, for such periods as they deem appropriate, if the code provisions when rigidly enforced would result in unreasonable hardship on the facility but only if such waiver will not adversely affect the health and safety of residents.

Exception No. 3. States may waive compliance with the Life Safety Code entirely if the Secretary of HEW makes a determination that their own fire codes protect patients equally as well.

Comment

The three exceptions to the requirement effectively nullify the standard. Exception No. 1 does substantial damage in exempting buildings which are often the most susceptible to fire. This exception applies to homes of 15 beds or less and homes treating the mentally retarded and those wth related conditions, i.e., muscular dystrophy, cerebral palsy, and developmental disabilities as well as alcoholics and drug addicts under treatment. It is doubtful that many of these individuals will be both ambulatory and capable of following directions for self-preservation in an emergency.

Exception No. 2 allows the waiver of all or part of the code *indefinitely* upon a showing of unreasonable hardship to the facility if the code provisions are rigidly enforced provided that such a waiver will not adversely affect the health and safety of the residents. The same reservations as expressed above about the use of these terms are repeated here.

Exception No. 3 allows the States still another way around the provisions of the Life Safety Code which is to obtain the Secretary's finding that their own State fire code protects patients equally as well. Unless such findings of "equivalency" are carefully evaluated and sparingly given by HEW, the effect will be total obscuration of this standard.

Parenthetically, the reason for the generous waivers from the fire safety provisions is that comparatively few ICF's presently meet the existing standards as mandated by Congress. The recent HEW study detailed that 59 percent of the SNF's in the nation were not in compliance with the Life Safety Code and it was projected that an even greater number of ICF's do not comply.[56] However, by not enforcing standards, HEW and the States are guaranteeing tomorrow's nursing home fires.

III. CONCLUSIONS

On November 29, 1971, as the White House Conference on Aging convened in Washington, D.C., Senator Frank E. Moss announced certain preliminary conclusions with respect to the findings of the Subcommittee on Long-Term Care having held 18 hearings up to that point. He enumerated five crucial problems.

The first and most significant problem was the absence of a policy with respect to the infirm elderly. Others were the existence of financial incentives in favor of poor care, the abdication of the physician from responsibility for nursing home patients, the reliance by nursing homes on untrained and unlicensed personnel, and the lax enforcement of nursing home standards.

Three years later, Senator Moss watched as HEW announced new ICF standards and combined regulations for Medicare and Medicaid skilled nursing facilities which effectively vitiated some 7 years of effort on his part—a reference to the Moss amendments of 1967 intended to raise nursing home standards. Senator Moss resolved to continue the battle for adequate protection for the nation's one million

[56] Washington Post, Jan. 16, 1974.

infirm elderly and added a sixth to the basic problems in the nursing home field: the absence of adequate nursing home standards.

RECOMMENDATIONS

This chapter deals with only one aspect of the nursing home controversy. The question of adequate standards merits this attention in view of its critical importance to the quality of care in the nation's long-term care facilities. In this context the committee has recommended:

The March 5, 1973, preliminary regulations for intermediate care facilities should be reinstated and finalized as the standards for intermediate care facilities.

The significant deletions and omissions HEW made from prior standards (The Conditions of Participation in an Extended Care Facility—otherwise known as the Medicare standards in effect until January 17, 1974) should be reinstated as part of the unified Medicare-Medicaid skilled nursing facility standards.

The question of nursing home standards and other significant issues will be covered in the committee's forthcoming report. The report covers 10 years of hearings by the Subcommittee on Long-Term Care (22 hearings were held since July 1969) and almost 5,000 pages of testimony.

A major recommendation of the report will be the need to enact a comprehensive policy with respect to the infirm elderly. There are some 4 million older Americans who need some type of nursing care from personal care to 24-hour-a-day skilled nursing home care. None of the current National Health Insurance proposals address themselves to these critical needs. Therefore, the committee recommends:

Expanding the current Medicare program to provide greater in-home services to treat individuals in their own homes if possible. S. 2960 and 2965 have been introduced by Senators Muskie and Church to effectuate this purpose.

Expanding the scope of Medicare to provide the full range of nursing home care. S. 1825 introduced by Senator Moss is addressed to this objective.

CHAPTER V

HOUSING: NEW STRATEGIES, OLD PROBLEMS

Housing for older Americans ran into major roadblocks during 1973, and new administration strategies were under fire early in 1974.

The sequence of events:

—In January 1973, the Department of Housing and Urban Development imposed a moratorium on major housing programs including several of special importance to the elderly.

—In September, HUD issued an anxiously awaited, 6-month study of all Federal housing policies. The HUD analysis proclaimed past programs as failures, including those serving the elderly. The HUD conclusions, however, were vigorously disputed by many persons who had been directly involved with the programs.

—Late in the year, HUD became fairly specific about plans to make housing allowances as the mainstay of departmental policy. Under this approach, direct cash assistance would be given to low-income persons who could then "shop" for suitable quarters. Among the major criticisms of this approach: (1) Many areas of the Nation have low vacancy rates and would offer little to "shop" for; and (2) housing allowances are not likely to stimulate new construction of units specifically designed for the elderly.

—The President's message on housing, delivered in September, then seemed to retreat even on housing allowances. It proposed more study [1] before widespread implementation of allowances.

—The President's budget message in February 1974 put special emphasis upon the section 23 Leased Housing Program [2] as the sole vehicle for subsidizing new construction. Proposed regulations, however, have raised questions as to whether this program would be of any help whatsoever to the experienced, nonprofit sponsor of housing designed with the special needs of the elderly in mind.

Hearings in New Jersey early in 1974 and reports from other parts of the Nation, meanwhile, indicated that rising rents, growing shortages of apartments, higher property tax rates, and deterioration of existing housing stock were compounding the housing problems of older Americans.

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[1] There are three major experimental components now underway in the housing allowance program: a demand experiment, a supply experiment, and an administrative agency experiment. Results from these experiments are not expected before the fall of 1974; however, a preliminary report is available: "First Annual Report of the Experimental Housing Allowance Program," HUD Office of Policy Development and Research, May 1973.

[2] See pp. 85–87 for details.

1. WHAT WAS "FROZEN" IN 1973?

Advocates and sponsors of housing for the elderly have grown accustomed to frustration and delay, but they were not prepared for the major announcements of January 5, 1973. After that date, subsidized housing and community development programs faced suspension and confusion, and, in some cases, termination.

A. The End Of Seven Community Development Programs

Effective January 5, 1973, the following programs came to a close: Open Space Land, Water and Sewer Facilities, and Public Utility Loans. By mid-year (June 30, 1973) four other programs were terminated: Model Cities, Neighborhood Facilities, Rehabilitation Loans, and Urban Renewal. While it is true that unspent money in these programs is available for use through the end of fiscal year 1974 (i.e., until June 30, 1974), no further expenditures in these programs will be approved, according to administration announcements.

The President's new domestic strategy assigns the primary responsibility for the solution of social problems to the State and local governments. Therefore, the administration argues that assistance for projects normally funded by the seven terminated programs must await successful passage of Special Community Development Revenue Sharing.

Bills to provide this form of revenue sharing have been introduced in both the House and the Senate.[3] The Senate has passed a Community Development bill (S. 3066, see p. 91) and awaits House action. Numerous controversial issues are still unresolved.

B. Public Housing, Section 236, and Rent Supplement

Effective on the close of business on January 5, 1973, the Nixon administration also announced a moratorium, or housing "freeze," on all new commitments for the subsidized housing programs.

It is important to note that this moratorium did not stop all new construction of subsidized housing units. Projects under preliminary loan contract in public housing and units with approved feasibility in FHA-assisted programs (such as section 236 multifamily housing) were allowed to proceed to construction. However, after January 5, 1973, no new units were approved.

The housing freeze brought indefinite delays to many specially designed projects for the elderly. The freeze affected the three programs most responsible for subsidized housing for older persons: Public housing, section 236 multifamily housing, and the

[3] See the Administration's proposed Better Communities Act (S. 1743—May 8, 1973); the Senate (Sparkman) Community Development Bill (S. 1744—May 8, 1973); and the House (Barrett-Ashley) Community Development Block Grants Bill (H.R. 10036—September 5, 1973).

Rent Supplement Program which worked in tandem with both section 236 and the section 221(d)(3) program.[4]

C. The True Impact: A Growing Time Lag

Experts in the field of housing report a minimum of 2 years, and more likely 3 years, of time lag between initiation of a project and actual occupation by tenants. Often, this time span can stretch well over 3 years, depending on the number of possible delays that can plague a project's development.

In 1972, the year prior to the moratorium, approximately 70,000 specially designed housing units for the elderly were approved in various programs. Under reasonable circumstances these units should be occupied by 1974 or 1975.

Project applications do not appear overnight, however, and if there is some kind of thaw in the freeze, or even if there is an announcement of a new housing program, there will be a time lag of at least a year when very few subsidized housing projects for the aged will be opening their doors to new tenants.

II. THE NEW ADMINISTRATION STRATEGY

Shortly after the initiation of the housing moratorium, President Nixon called for a sweeping study of Federal housing policy.[5] The study took 6 months and is the basis for the new administration recommendations.

The President, in a message to Congress on September 19 proposed that the Government provide housing allowances for poor and moderate-income families rather than continue what he described as a wasteful, inequitable system of subsidizing housing for the needy to live in. His message, as it relates to low-income housing, can be summarized in three parts.

A. The Past: The "Failure" of Federal Housing Programs

The President said that the Federal Government has provided nearly $90 billion for public and subsidized housing since 1937.

Citing such dramatic examples as Pruitt-Igoe in St. Louis,[6] the President said that current programs have produced some of the worst housing in America. Recognizing that some good housing had been built, he asserted, "All across America, the Federal Government has become the biggest slumlord in history."[7]

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[4] 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 one percent and the Federal Government pays the interest difference between one percent and the interest charged by the financing agency.

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.

[5] State of the union message on community development, Mar. 8, 1973, Congressional Record, pp. S. 4120–23, at p. S. 4122.

[6] Pruitt-Igoe is a massive public housing project in St. Louis that has been partly demolished, and now is scheduled to be completely torn down. As built, it included 33 11-story buildings of 2,800 low-rent apartments on 57 acres. Over $75 million was spent to build it and in attempts to improve it.

[7] Federal Housing Policy—Message from the President, Sept. 19, 1973, Congressional Record, pp. S. 16861–16866, at p. S. 16864.

He also concluded that Federal involvement in housing was inefficient. His 6-month study reported that it costs between 15 and 40 percent more for the Government to provide housing for people than for people to acquire that same housing themselves on the private market.[8]

Current programs were also cited as inequitable because they arbitrarily select only a few low-income families to live in federally supported housing, while ignoring others.

Finally, the President criticized the lack of freedom to choose under the present programs. In his words, housing is offered on a "take it or leave it" basis without giving the person the basic right to choose where he wants to live.

Relying on this four-part criticism, the President, with a few exceptions, decided to keep the housing freeze in effect and not return to former programs.

B. The Future: Housing Allowances Beginning With The Elderly Poor

After analyzing possible alternatives for housing low-income people, the administration rejected the old programs and is moving in the direction of direct cash assistance, more commonly referred to as housing allowances. Under this approach, instead of providing a poor family with a place to live, the Federal Government would provide qualified recipients with an appropriate housing payment and would then let them choose their own quarters on the private market. The President expressed his belief that the root cause of the housing problem was not a lack of housing but a lack of income, therefore he concluded:

> Not surprisingly, our recent housing study indicates what others have been saying: of the policy alternatives available, the most promising way to achieve decent housing for all of our families at an acceptable cost appears to be direct cash assistance.[9]

The word "appears" should be notably emphasized in this statement, for by no means has the administration firmly committed itself to housing allowances. Instead, they view it as the "most promising" approach.

The President has, therefore, called for an expansion of the existing experimental program to test the feasibility of housing allowances. Experiments on a smaller scale were first initiated pursuant to section 504 of the Housing and Urban Development Act of 1970. If the expanded experimental program can be effectively concluded as scheduled, the administration expects to make a final decision on housing allowances in late 1974 or early 1975.

This decision will have a special impact on the housing possibilities for the elderly. Implementation of direct cash assistance can-

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[8] Ibid., at p. S. 16864. *See also* Housing In The Seventies, preliminary draft, Oct. 6, 1973, ch. 4.

[9] Federal Housing Policy—Message from the President, Sept. 19, 1973, Congressional Record, at p. S. 16864.

not occur all at once. Payments to all low-income persons would certainly cause a rapid inflation in rents. Therefore, the program must be initiated gradually. The administration has made it clear that it intends to begin, after final clearance, with the poor elderly.

C. The Present: A Partial Thaw and the Emergence of Section 23

Whether the Federal Government turns to housing allowances or not, a critical question remains. What of the need for more low-income housing in the meantime?

The President's message made it clear that certain areas of the country face an insufficient supply of housing for the foreseeable future. He, therefore, approved assistance for construction of low-income housing, although he emphasized that the construction approach would be used "sparingly."

Central to the administration's limited commitment to more construction is the section 23 program.[10] Originally slated as a program to be used only with existing housing, section 23 would be adapted to produce new construction. The developer would make newly constructed units available at special rents for low-income families, and the Government, in return, would pay the developer the difference between such rents and fair market rents.

How many units of new construction will be approved? An accurate estimate of long range assistance for new construction is difficult to make. Based on the best available evidence, the following forecast can be made.

FISCAL YEAR 1974

In his message to Congress, President Nixon announced new authorization to process an additional 200,000 units, 150,000 of which would be for new construction. These units represent a partial thawing of the moratorium, picking up subsidy applications for units which had moved most of the way through the application process by January 5, 1973. The figures also represent brand new applications under the section 23 program. The program breakdown is as follows:

Program:	*Units estimated*
Section 23 (existing housing)	50,000
Section 23 (new construction)	80,000
Other subsidized housing: (section 236 and section 221(d)(3) coupled with rent supplement) (10,000 for rehabilitation)	70,000
Total	200,000

It should be noted that the 130,000 units approved under the section 23 program will be processed through local housing authorities. The remainder will go to eligible sponsors through the following priority categories:[11]

[10] Section 23 was added to the United States Housing Act of 1937 by sec. 103(a), Housing and Urban Development Act of 1965, P.L. 89-117, approved Aug. 10, 1965, 79 Stat. 451.

[11] Housing Affairs Letter, Nov. 2, 1973, at p. 7.

Program category:	Units
Operation Breakthrough	2,660
Project Rehab	10,641
Annual arrangement cities	9,523
New communities	2,158
Urban renewal-relocation—neighborhood development program	41,641
Co-ops	2,280
Total	68,903

It should be carefully noted that there is no policy or written commitment that any portion of these 200,000 units for fiscal year 1974 must go for housing for the elderly. But it should be safe to estimate that a large proportion will be approved for the aged.

Current figures show that approximately 40 percent of all new public housing units are for the elderly, and since all the section 23 units (130,000) will be administered through public housing, it is not unrealistic to predict that many units will be provided for older persons.

FISCAL YEAR 1975

The Department of Housing and Urban Development has requested contract authority to approve 300,000 units of section 23 in fiscal year 1975.[12] They plan to use no other subsidy program for new units.

FISCAL YEAR 1976

Construction subsidies for 1976 are anyone's guess at this time. All indications from HUD thus far seem to indicate that they will not forego subsidizing new construction altogether, even if they go ahead with housing allowances. One possible guess is that HUD will provide assistance for a "supply function" as part of an overall approach using section 23 altered to allow nonprofit and limited dividend sponsors to negotiate directly with HUD instead of through local housing authorities.

III. HOUSING ALLOWANCES AND SECTION 23: SOME MISGIVINGS

The section 23 Leased Housing Program (as revised) is beginning to look, for the time being, like "the only game in town." Congress is still some months away from passing any major housing legislation, and the administration is showing no signs of returning to old programs that they froze in early 1973. Although a Senate bill (S. 2182)[13] calls for a combined subsidy approach using the section 502 (formerly section 236) and the revised section 23 programs, it is far from certain whether this combination will still exist when the bill finally clears Congress.[14]

[12] HUD news release, Feb. 4, 1974.

[13] S. 2182 served as the major vehicle for housing legislation and was reported out of subcommittee on Feb. 7, 1974, and received a new number (S. 3066) when referred to the Senate floor.

[14] There is reasonable doubt whether the bill will pass at all. As in 1972, the process in the House may be slow. If a House bill is reported out late, chances are slim that it will reach the House floor in an election year.

A. Section 23: Are the Nonprofits Excluded?

In 1965, Congress added section 23 to the United States Housing Act, enabling local public housing authorities to lease units in private structures for occupancy by low income families.[15] As originally intended, this program was for leasing *existing* units only, instead of subsidizing new construction.

HUD soon stretched the language of this section to create a new Construction for Leasing Program. In 1970 Congress ratified HUD's action through an amendment to section 23 that permitted lease terms of up to 20 years for newly constructed units. In his housing policy statement of September 19, 1973, President Nixon fully embraced the section 23 program:

> I am advised by the Secretary of Housing and Urban Development that one of the existing construction programs—the section 23 program under which new and existing housing is leased for low-income families—can be administered in a way which carries out some of the principles of direct cash assistance. If administered in this way, this program could also provide valuable information for us to use in developing this new approach.
>
> Accordingly, I am lifting the suspension of January 5 with respect to these section 23 programs.[16]

It should be emphasized that section 23 is a *leasing* program. In other words, neither the Federal Government nor the local housing authority will be the landlord. Under revised regulations,[17] the new section 23 program will significantly increase the role of private owners who participate in that they will own, operate, and maintain units leased to low-income families. Tenants who live in privately owned leased housing will assume added responsibility as well, since they will make rental payments directly to the private landlord instead of to the local housing authority.

Section 23 fits neatly into the housing allowance concept, because the Federal Government will provide to owners of units covered by section 23 subsidies equal to the difference between the fair market rents of comparable standard units in each housing market area and the amount of rent paid by eligible families. No family will pay more than 25 percent of its adjusted income for rent.

It remains to be seen how effectively the revised section 23 program will work. How promising section 23 will be for the elderly is especially unclear.

As originally promulgated,[18] the regulations for the new program gave priority to applications for projects asking for less than 20 percent of their units to be leased under section 23. This regulation was of grave concern to sponsors of elderly projects who knew the unique

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[15] See footnote 10.
[16] Federal Housing Policy—Message from the President, Sept. 19, 1973, Congressional Record, at p. S. 16864–65.
[17] See Federal Register, Jan. 22, 1974, pp. 2533–2561.
[18] See Federal Register for Nov. 9, 1973, pp. 31023–31030, and Nov. 15, 1973, pp. 31550–31555.

advantages of a building that is specially designed and exclusively operated for older persons.

However, James T. Lynn, the Secretary of HUD, has indicated that he will allow 100 percent occupancy by the elderly:

> The comment period on the regulations will soon expire, and we shall be carefully evaluating all of the comments we have received. But without prejudging decisions that will be made at that time, I think I can assure you now that we will be providing in the regulations which become effective for projects which will permit up to 100% of the units to be under subsidy in the case of elderly or handicapped tenants.[19]

Under the section 23 program, the administration is planning to approve 300,000 units in fiscal year 1975. Secretary Lynn has also indicated that he will reserve "something like 25 percent" of the contract authority for units of section 23 for use by the elderly and handicapped.[20]

Despite these attempts by the administration to adapt their program to the needs of the elderly, the experienced nonprofit sponsors, who have produced so many projects for the elderly, are deeply concerned. They feel excluded from participation in section 23.

Under current law, units built under section 23 must be processed through the local housing authorities, and, therefore, nonprofits *cannot* deal directly with HUD. Local housing authorities must first certify a need for units in their community with the local HUD Area Office. If the area office approves a number of units, the local housing authority must then ask for bids. Nonprofit sponsors, such as religious organizations, labor unions, and service organizations, are convinced that they will be continually outbid by private developers who have the necessary staff and seed money to put an application together.

To help alleviate this situation, HUD has under consideration a proposal whereby contract authority would be allocated to State housing finance agencies. Under this method, the State agencies could work directly with the nonprofit sponsors and avoid the bidding process.[21] This proposal may bring some relief. However, at least 40 percent of the States do not have housing finance agencies. In addition, many State agencies are so new that they are not in a position to deal effectively with Section 23. Presumably, State agencies would also have the option not to use section 23 altogether.

The administration has introduced legislation (S. 2507) that would enable nonprofit sponsors to apply *directly* to HUD under section 23. However, it may be months before such legislation is passed. Meanwhile, the nonprofits may be excluded from the program altogether.

B. Housing Allowances: Are They Enough?

On its face, a housing allowance for an elderly person has a lot to say for it. In theory, it should make up the difference between 25

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[19] Letter to Representative William B. Widnall, Feb. 4, 1974. See Congressional Record, Feb. 5, 1974, at p. H 508.

[20] Ibid.

[21] Ibid see also, Federal Register, March 19, 1974.

percent of an older person's income and the cost of a standard rental unit in his community. The theory is questionable, however, in an area of the country where the vacancy rate is so low that there is effectively no existing supply of housing to be found.

President Nixon has clearly indicated that he prefers an income approach instead of a construction approach. In his September message to Congress, he complained that the root cause of poor housing was not a lack of supply but an inability to pay for it.

Although the administration has indicated plans to approve 300,000 units of section 23 in fiscal year 1975, it is clear that this emphasis is an *interim* measure while experiments with the housing allowance program continue. The President said, referring to Government assistance for construction: "I would expect to use this approach sparingly." [22]

If the major emphasis in national housing policy is to shift from new construction to a housing allowance or income approach, the results could be very serious for the elderly.

Many areas of the country, especially the Northeast, face critical housing shortages. For example, New Jersey has a vacancy rate of only 1.85 percent.[23] Many large cities also suffer low vacancy rates: Jersey City 1.0 percent, Baltimore 1.8 percent, Philadelphia 2.1 percent.[24] Where the standard housing supply is so low, an elderly person will be hardpressed to find a suitable place to live, even with a housing allowance. Many experts have expressed the opinion that housing allowances in a market of short supply will only serve to push rents up higher and provide an added windfall to slum landlords.

Reliance solely on housing allowances could also bring to an end the construction of housing projects designed specially for the low-income elderly. The deficiencies in the housing allowance approach were clearly stated in a recent HUD publication entitled the "First Annual Report of the Experimental Housing Allowance Program": [25]

> . . . it should be realized that because of cost housing allowances can be made applicable only to offset the rents or sales prices of *existing* housing. . . . As such, the program is unlikely to fulfill the objectives of a new housing program (1) by adding directly to the housing supply, or (2) by meeting special housing needs not adequately met by the existing supply, such as elderly units or units for large families. . . .

In short, a national housing policy that continues to ignore the very real need for new construction of standard housing, will make it increasingly difficult for older persons to find decent housing, and will effectively block the construction of specially designed housing units for the poor elderly.

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[22] Federal Housing Policy—Message from the President, Sept. 19, 1973, Congressional Record, p. S. 16864.

[23] Vacancy rates supplied to committee by the New Jersey Office on Aging (based on 1970 Census data).

[24] HUD news release, Aug. 22, 1973, based on HUD's 18th semiannual summary of the post office surveys made from July through December 1972.

[25] HUD publication (HUD–PDR–29–6) published by the Office of Policy Development and Research (May 1973).

IV. LEGISLATION FOR THE ELDERLY

No major housing legislation passed either the House or the Senate during 1973. Repeated attempts to lift the moratorium and release impounded funding made little progress. The Congress found itself in a position of having established programs and appropriated money, and yet, they were unable to force the administration to proceed.

When the President's message in September flatly rejected the old approaches, hope of passing any major legislation was put off until 1974.

A. The Housing Act of 1973 (S. 2182): [26] A Repeat of 1972

Impatient with the housing freeze and the 6-month study, Senator John Sparkman, chairman of the Senate Banking, Housing and Urban Affairs Committee, introduced on July 14 the Housing Act of 1973. In short, this bill was a repeat of the Housing and Urban Development Act of 1972 (S. 3248) which passed the Senate but not the House. As introduced, the Housing Act of 1973 has several provisions which would directly affect the elderly:

(1) Funding authorized for new construction under traditional public housing.

(2) Not less than 15 percent nor more than 25 percent of the funding for section 502 housing is reserved for housing for the elderly. Section 502 is the multifamily housing section which essentially incorporates the old section 236 program.

(3) Up to 100 percent of the housing units in a project for the elderly may utilize the Rent Supplement Program. (Combined as part of Section 502). Current law allows only 40 percent, and current practice averages less than 10 percent.

(4) In determining prototype costs, the Secretary of HUD must take into account the special costs of units designed for the elderly.

(5) The bill also provides for supplemental improvement loans for section 502 elderly projects to finance additions or improvements necessary to expand the common facilities of a project so that they may be used by elderly persons residing in the neighborhood.

(6) Five percent of the funds in the section 502 program reserved for the elderly must go to projects that are integrated by age (i.e., projects with 10 to 50 percent elderly).

(7) The Secretary shall encourage local housing authorities to meet the special needs of projects for the elderly through "congregate housing." Congregate housing is defined as low-income housing with a central dining facility in which some or all of the units do not have kitchen facilities.

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[26] Introduced by Senator Sparkman on July 14, 1973. See Congressional Record, at p. S. 13473 (not reproduced).

B. The Williams Package: A New Look For 202

Administration policy, laced with impoundments, moratoriums, and program terminations offered little to the elderly beyond further experimentation and study.

Continuing to press for a national housing policy for the elderly and a construction program for housing specifically designed for older Americans, Senator Harrison A. Williams, introduced a package of four bills in July.

These bills called for the following action:

(1) *Extension of the Section 202 Program (S. 2185).*[27] This bill increases the authorization level of the popular section 202 Housing for the Elderly and Handicapped Program from its current level of $650 million to $750 million.

(2) *Demonstration Direct Loans for the Elderly (S. 2179).*[28] Despite great success, the section 202 program has not been used since 1970. The section 202 program has been put aside because it is a direct loan program requiring that the full mortgage amount for each project be loaned out at one time. Federal accounting policy requires that all direct loans be tabulated on a "net lending" basis. Essentially this means that all receipts and disbursements in a direct loan program are combined, and the remainder becomes part of the annual budget. Any direct loan program in its early years will disburse much more than it will receive. Because the section 202 program had such a direct impact on the annual budget, it has not been used. S. 2179 is an attempt to overcome this budgetary objection. As written, this bill calls for the Treasury (on a demonstration basis) to establish the National Elderly and Handicapped Housing Loan Fund. The Treasury would borrow money at Government rates which would then be loaned out through the Secretary of HUD, subject to provisions governing mortgages under the section 236 program.[29] All receipts and disbursements of the fund would be excluded from the annual budget.

(3) *Intermediate Housing for the Elderly and Handicapped Act (S. 2181).*[30] "Intermediate" housing is aimed at serving those elderly and handicapped who do not need nursing home care, and yet, cannot live independently without some supportive services. Based on a successful program completed by the Philadelphia Geriatric Center, S. 2181 provides for interest-subsidy payments (identical in form to the section 236 program) to rehabilitate *existing* housing and convert it to units suitable for the elderly. It is intended that the converted units be in close proximity to an established center for the elderly capable of providing supportive

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[27] See Congressional Record, July 14, 1973, at p. S 13474.
[28] See Congressional Record, July 13, 1973, at p. 13362.
[29] Section 236 of the Housing Act of 1968 is an interest-subsidy program for multi-family 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.
[30] See Congressional Record, July 13, 1973, at p. 13364.

services. In Philadelphia, for example, eight single family houses were converted so that each provided three efficiency apartments across the street from the center.

(4) *The Housing Security Act of 1973 (S. 2180).*[31] Responding to the disproportionate number of elderly who are victims of crime, this bill establishes an Office of Security at HUD and provides funding specially earmarked for needed security programs in all HUD-assisted housing.

C. Status of Housing Legislation

None of the bills mentioned above has been reported separately out of the Housing Subcommittee of the Senate Banking, Housing and Urban Affairs Committee. Chairman Sparkman's bill (originally S. 2182, now S. 3066, the Housing and Community Development Act of 1974) will be the major vehicle for housing legislation in 1974. The four Williams proposals have been approved and incorporated into S. 3066 as follows:

(1) *The "New" Section 202 Program.* Combining parts of S. 2185 and S. 2179, the Housing Subcommittee approved a return to the section 202 program with certain financing changes. The subcommittee approved the new National Elderly and Handicapped Housing Loan Fund as proposed under S. 2179, but attached it to the section 202 program rather than to the section 236 program. The revolving fund that now exists under the dormant section 202 program would become part of this new fund. As mentioned previously, all receipts and disbursements under this new fund would be excluded from the annual budget to overcome the objection to the direct loans. Opposition to this approach may be expressed by the Office of Management and Budget and the Treasury Department because it conflicts with their policy of treating direct loans on a "net lending" basis (see discussion above).

(2) *The Housing Security Act of 1973.* S. 2180 has been approved by the Housing Subcommitee. (See p. 93–94.)

(3) *Intermediate Housing.* In concept, the provisions of S. 2181 were approved by the Housing Subcommittee, but no bill language will reflect this approval. Because the subcommittee approved a return to the section 202 program, and because current section 202 law permits rehabilitation and conversion, no new law was required to fulfill the objectives of S. 2181. Nevertheless, language supporting and recommending the "intermediate" housing concept will be included in the report of the committee.

In summary, the bills introduced by Senator Williams made notable progress in 1973. The fate of the Williams proposals was tied to S. 3066, Sparkman's Housing Act of 1974.

The Sparkman bill was reported out of subcommittee on February 7, 1974, and passed the Senate on March 11, 1974. However, House action on a similar major housing package is farther behind.*

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[31] See Congressional Record, July 13, 1973 at p. 13363.

* The House Housing Subcommittee reported out a much shorter Housing and Community Development Act (H.R. 14490) on April 30, 1974.

V. ADDITIONAL ISSUES

A. Property Tax: The Circuit Breaker Approach

Two important pieces of legislation were introduced in 1973 to relieve the low-income homeowner and renter from rapidly increasing property taxes. Both bills are structured to encourage State and local governments to reform their real property tax systems by calling for the Federal Government to reimburse the States and local governments for 50 percent of their losses if they will institute reforms and establish systems meeting certain requirements. Both of these bills feature the so-called "circuit breaker" system which provides relief to homeowners and renters of a certain income level by requiring them to pay no more than a set percentage of their income for property tax. In other words, if their property tax rises to a point that exceeds the set percentage level, they will be eligible for relief (the "circuit is broken").

THE EMERGENCY PROPERTY TAX RELIEF ACT (S. 471)

On January 18, 1973, Senator Frank Church introduced the Emergency Tax Relief Act.[32] Under this approach, Federal assistance would be available for States which meet certain minimum requirements for property tax and rental relief programs for elderly households with incomes up to $6,000. The States, however, would still be free to extend this relief to aged families with incomes above $6,000.

Under the Church bill, a "tier" or "step" system would be built into the "circuit breaker" approach to direct the relief to older persons in greatest need.

Elderly homeowners with incomes of $3,000 or less will receive relief if their tax exceeds 4 percent of their income. Thereafter, the circuit breaker" threshold increases by 1 percent for each $1,000 of family income until it eventually reaches 7 percent for persons in the $5,001 to $6,000 income category.

Elderly renters will also be eligible for relief if their incomes are under $6,000, and if their gross rent exceeds 25 percent of their income.

PROPERTY TAX RELIEF AND REFORM ACT OF 1973 (S. 1255)

In an effort to bring property tax relief to low-income homeowners and renters, including the elderly, Senator Edmund Muskie introduced the Property Tax Relief and Reform Act of 1973.[33] Under the Muskie bill, relief programs will rebate the excess of property taxes on a residence when the excess is over 3 percent of household incomes up to $3,000, over 4 percent on incomes up to $7,000, over 5 percent on incomes up to $10,000, and over 6 percent on incomes up to $15,000.

Renters with incomes under $15,000 will also be eligible for assistance. The States will have the flexibility to set the relationship between rent and property taxes.

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[32] S. 471, referred to the Senate Committee on Finance. See Congressional Record, Jan. 18, 1973, at p. S. 952.

[33] S. 1255, referred to the Committee on Government Operations. See Congressional Record, Mar. 15, 1973, at p. S. 4858.

The Intergovernmental Relations Subcommittee of the Senate Government Operations Committee held hearings in 1973 which discussed property tax relief and the Muskie bill in particular. No further action has been taken.

B. Security: Some Losses, Some Gains

Lack of funding continues to be the major issue in the field of security from crime and personal injury in HUD-assisted housing. Many different examples of security programs throughout the country have exhibited remarkable success in curbing crime and improving security. Methods of providing security for the elderly have been particularly successful. Very simply, the problem is not one of finding answers. Solutions are readily available; money to pay for them is not.

In public housing, where the security problem has been most acute, local housing authorities have been unable to find sufficient funding from their own budgets for security. Even with the aid of operating subsidies from the Federal Government, local housing authorities have had severe problems meeting even their most basic needs. As a result, they have turned to other sources for assistance.

FUNDING SOURCES LOST

During 1973, three of these "outside sources" dried up. A few housing authorities obtained funding for security from local Model Cities programs. Model Cities was terminated on June 30, 1973, except for unspent carryover funds. Under the Emergency Employment Act (EEA), salaries for guard services were available for housing security programs, but the administration has not refunded EEA. And finally, the HUD modernization program which made funds available for capital improvements such as lighting, hardware, and design modifications was suspended on June 30, 1973. The budget message for fiscal year 1975 calls for continued funding of the modernization program, but no money is set aside specifically for security.

ADMINISTRATION RESPONSE

During the past year the Department of Housing and Urban Development has made efforts to address the need for better security. On September 10–12, 1973, HUD sponsored a national conference on "Security in Multifamily Housing" in Washington, D.C., where they revealed the draft for a new HUD handbook entitled "Security Planning for Multifamily Housing." But no funding commitment was made.

HOUSING SECURITY ACT OF 1973

Senator Williams introduced the Housing Security Act of 1973 (S. 2180) on July 13, 1973. The Williams bill would establish an Office of Security at HUD and authorize funds specifically earmarked for security programs. The Housing Subcommittee of the Senate Banking, Housing and Urban Affairs Committee approved a major housing

bill [34] which includes all the provisions of S. 2180. The subcommittee also approved an authorization reserving $10 million of operating subsidy for security for fiscal year 1975. This action represents the first time that funding has been separately set aside for security in HUD-assisted housing.

A NEW DEVELOPMENT

One new idea for security for the elderly has received considerable attention. This approach would shift the elderly tenant population in public housing so that all older persons are living in buildings reserved for the aged. No elderly tenants would live in mixed housing (with younger tenants). Where this program has been tried, there has been a significant drop in the crime rate (even in neighborhoods with severe crime problems). These results are not surprising when one considers that statistics show that the elderly experience the most crime in buildings that are mixed, and crime *inside the building* can be removed 100 percent when the building is occupied only by older persons.

Senator Williams wrote to Mr. H. R. Crawford, Assistant Secretary for Housing Management at HUD, asking him to explore this approach and to indicate an estimate of how much it would cost. In his letter Senator Williams stated:

> My feeling is that we are not talking about an unwieldly number of units. While I am strongly committed to providing funding for security to help all tenants suffering from crime, I feel that placing the elderly in their own buildings is a simple, proven, dramatically effective and inexpensive means of providing increased safety.
>
> The public housing projects which are experiencing the worst crime and vandalism problems and highest vacancy rates consist of high-rise elevator buildings. Paradoxically, if these high-rise buildings were turned over exclusively for elderly use, they would become fully occupied and crime-free.[35]

HUD officials have indicated that they, too, feel this approach is "most promising." [36] Assistant Secretary Crawford has instructed his staff to prepare recommendations for HUD action to encourage local housing authorities to use this approach. As yet, HUD will provide no estimate of what this would cost on a national basis, and they have not requested any special funding for this purpose.

C. Fire Safety: New Regulations Adopted

Following a tragic fire in a new section 236 project for the elderly,[37] Senator Harrison A. Williams, Chairman of the Subcommittee on

[34] This bill (originally S. 2182) was reported out of Subcommittee to the Banking, Housing and Urban Affairs Committee on Feb. 7, 1974. It received a new number, S. 3066, and was passed by the Senate on March 11, 1974.

[35] Letter from Senator Harrison A. Williams to H. R. Crawford, Nov. 16, 1973.

[36] Letter from HUD Assistant Secretary H. R. Crawford to Senator Harrison A. Williams, Dec. 12, 1973.

[37] Baptist Towers Apartments in Atlanta, Georgia. Ten persons died as a result of a fire in this project on Nov. 30, 1972.

Housing for the Elderly, held hearings to explore the problems of fire safety in highrise buildings for older persons.[38]

At that hearing, officials from the Department of Housing and Urban Development reported that HUD had under consideration revisions of their minimum property standards which would greatly improve the fire safety requirements for this type of building.

These regulations became effective in November 1973, and included the following requirements:

(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

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

The new regulations 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 only $200 per building.

In addition—although these new regulations represent a distinct improvement in fire safety in HUD-assisted buildings—they apply only to projects approved after November 1973; they are not retroactive. There still remains a serious need to help existing buildings, and buildings approved before November 1973, to finance improvements in their fire safety systems.

D. New Dimensions of Need

Mr. Allan F. Thornton, Director of the Division of Economic and Market Analysis at HUD, in a recent speech estimated that between 400,000 and 500,000 units could be sold to the elderly on a yearly basis if they were specially designed for their needs.

This estimate was based on providing housing with no subsidies. If subsidies were included, Mr. Thornton indicated that the estimate could double to 800,000 units per year or more.

Specifically, Mr. Thornton concluded:

> I might make a personal projection that demand for units which ideally meet the needs of elderly might be as much annually as double the customary demand by elderly households. By ideal units, I mean units which for the elderly provide physical security (both from violence and accident), health care (availability of nursing and medical services), daily needs (food, rest, and recreation), and convenient transfer or

[38] "Fire Safety in Highrise Buildings for the Elderly," hearings before the Subcommittee on Housing for the Elderly, Senate Special Committee on Aging, pts. 1 and 2, Feb. 27 and 28, 1973.

disposition of both home furnishings and equity in owned homes.

With these ideal qualities, perhaps 400,000 to half a million units annually might be sold to elderly—including both new and existing units.[39]

For years, experts in the field of housing for the elderly have been talking of the growing market for special housing for older persons, but they have never been able to quantitate that demand with any accuracy. Mr. Thornton's work represents a major step in the direction of measuring that demand on the basis of reliable analysis.

It is interesting to compare the following figures. The White House Conference on Aging called for a minimum yearly subsidy of 120,000 units for the elderly, and Dr. Thornton has predicted a measurable demand in the 400,000 to 800,000 unit range. In 1974, the Special Committee on Aging hopes to obtain a further analysis of Mr. Thornton's work with special attention to demand analysis on a local basis.

NEW JERSEY HEARINGS

Senator Williams' Subcommittee on Housing for the Elderly traveled to New Jersey in January 1974, to measure the impact of the housing freeze and to hear new testimony on the growing crisis in housing for older persons. New Jersey is the most urbanized State in the country, and as such, provided a vivid contrast of urban and suburban approaches to housing the aged.

Statements by several witnesses emphasized the need for suburban communities to take more of a role in providing low-income housing for older persons. All too often in New Jersey, and in many other States, long-time residents of suburban towns develop the need for low-cost housing. Against their wishes, they must seek help in the nearby urban areas. Large cities that find it difficult to supply adequate housing to their own elderly citizens, cannot begin to meet the added demand of the aged who come in from suburban areas where no inexpensive housing exists at all. Many witnesses recommended the county-wide housing authority as a possible response to this problem.

The New Jersey Office On Aging provided a thorough analysis of the income levels of the elderly in their State. Over 46 percent of elderly households in New Jersey have incomes below $3,000. Recent Social Security increases and the new Supplementary Security Income program have not helped solve the problem. The numbers of elderly with incomes under $5,000 remains essentially the same, and these new increases have not affected the ability of the elderly to compete effectively in today's private housing market.

FINDINGS AND RECOMMENDATIONS

The administration's new housing proposals are unacceptable to older Americans who need housing assistance. Criticism of old programs has ignored the fact that housing projects built for the elderly have been very successful.

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[39] Thornton, Allan F., "Dimensions of the Older Adult Market in the United States," speech delivered at the International Symposium for Housing and Environmental Design for Older Adults, Dec. 12, 1973, Washington, D.C.

Housing for older persons continues to be lost in the shuffle of larger, more general, policy recommendations. There is still no national policy for housing for the elderly, and there is still no effective representative for older persons at HUD with direct access to policy and decisionmaking.

Housing allowances may prove helpful in some parts of the Nation, but they will not be helpful in areas with a short supply of units. Therefore, a program of housing allowances without provision for the construction of new units is unacceptable.

The new section 23 Leased Housing Program, as recently revised, is considered unworkable by the nonprofit sponsors of housing for the elderly, and they are left with no building program they can use.

To renew the steady flow of construction of new units specially designed for the elderly, and to give greater exposure to the growing demand for housing older Americans, the committee recommends that:

(1) A national policy for housing for the elderly be established.

(2) Funding for new construction under section 236 and public housing be restored with a certain proportion set aside for the elderly.

(3) The section 202 program be renewed with changes to avoid direct impact on the federal budget.

(4) Changes be made in the new section 23 Leased Housing Program to enable nonprofit sponsors to participate in the construction of new units.

(5) Special programs, such as "intermediate" housing and "congregate" housing, be encouraged to provide living arrangements that are alternatives to institutional care.

(6) An overall minimum of 120,000 new units for the elderly be approved on an annual basis.

(7) An Assistant Secretary for Housing for the Elderly be established at HUD.

In addition, the committee recommends that:

(1) An Office for Security from Crime be established at HUD, and that funding be earmarked to develop and pay for security systems at public housing projects faced with serious crime problems.

(2) National legislation be passed encouraging the States to establish "circuit breaker" programs of tax relief for low-income elderly homeowners and renters.

(3) Low-interest loans be made available to HUD-assisted housing projects for the purpose of improving their fire safety systems.

(4) Local and regional analysis of the market conditions for housing for the elderly be continued by HUD based on the work already completed by the Division of Economic and Market Analysis.

CHAPTER VI

THE ENERGY CRISIS: WHAT IMPACT ON OLDER AMERICANS?

Closed gasoline stations, diminished heating fuel stocks, and soaring fuel prices began to make an impact on the life-styles and pocketbooks of older Americans in the closing months of 1973. Travel had to be curtailed; homes became colder; and budgets already stretched by inflationary costs of food and other essential items were hard hit by rising fuel costs.

Short-term assessments of the crisis is somewhat bleak for older Americans, particularly those on fixed retirement incomes, because of the effect of rising fuel costs on inflation. Almost every product and every service has a built-in fuel cost. As these prices rise, manufacturers and businessmen pass on the cost to consumers and thus the cost-of-living can only be expected to continue to rise in 1974.

Jobs are being lost in the transportation and tourist industries and in some industries which use petrochemicals as raw materials. Older Americans who lose their jobs in such cutbacks will not find it easy to obtain reemployment as the unemployment rate climbs.

Elderly people in frail health may find it more difficult to keep warm not only at home but in stores, churches and public places. They will find it more difficult to get to the doctor or to participate in the new nutrition program if they have to depend upon automotive transportation.

I. COST-OF-LIVING IMPACT

Fuel prices in the first 9 months of 1973 had been increasing, but the rate of increase was mild compared to the escalation that occurred in the last quarter due to the energy crisis. Jumps in gasoline, fuel oil, and coal prices contributed greatly to the fact that the inflationary rate for the last quarter was the highest since 1951. Gasoline rose about 12 to 15 cents per gallon and fuel oil and coal rose some 15 percent.

Higher prices were caused not only by a shortage of oil from the Arab world but the relaxation in price controls. The Cost of Living Council and Federal Energy Office allowed some prices to go up and decontrolled others completely in a move to encourage more domestic production. The immediate effect, however, was to jump prices and raise profits for the oil companies.

The general impact of inflation on older Americans is discussed in chapter I. Rising fuel prices will worsen this effect not only because older people must purchase fuel but because it is a component part of so many other goods and services. Hospital costs could rise still

further because of added fuel costs; food processing and delivery needs fuel; added heating costs could cause rent hikes; taxi and bus fares are affected by gasoline prices and availability. Thus, the fuel crisis can be expected to accelerate the rate of inflation in 1974.

II. EMPLOYMENT IMPACT

As 1974 opened, the Labor Department reported that the number of unemployed workers who attributed their job loss to the fuel shortage tripled from the last week in December to the first week in January. Seven percent of all persons collecting unemployment insurance benefits in the week ended January 5 said they lost their jobs because of the fuel shortage.

The first employment impacts have been felt in closed gasoline service stations, closed production lines of assembly plants which produce large cars, airline cutbacks in flights and employment, and reduced occupancy rates in hotels and motels.

Just how badly the tourist and entertainment businesses will be affected remains to be seen. Some 70 percent of all tourist travel is by automobile. If gasoline shortages continue this summer, the impact could be serious on the many small businesses run by older people and those who find part-time and seasonal employment in tourist related trade.

Some businesses have had to close because of the energy shortage. Those most vulnerable to shutdown because of lack of fuel or raw materials are the smaller manufacturing plants which operate on narrow profit and loss margins. Traditionally, these plants employ many older people.

Overall projections on the unemployment rate for 1974 vary from about 5.5 percent to a pessimistic 9 percent. The 1973 average was 4.9 percent.

III. IMPACT ON PROGRAMS SERVING OLDER AMERICANS

Programs providing services to the elderly have been adversely affected by the increased cost of fuel and shortages of essential petroleum products. Although the real significance of the crisis cannot be fully weighed as yet, a number of incidents indicate the dimension of the problem.

A. Volunteer Activities

Increased costs of gasoline and long waits to obtain fuel have had a negative impact on volunteer activity. During a hearing before the Senate Committee on Aging in February 1974,[1] Jack Ossofsky, Executive Director of the National Council on the Aging stated:

> Perhaps the most critical and far-reaching effect of the energy crunch on service agencies has been their loss of volunteer drivers. The loss has stemmed from two factors: the inability of the drivers to get gasoline or, if available, its high

[1] "Transportation and the Elderly: Problems and Progress", hearings before the Special Committee on Aging, Feb. 25, 1974.

cost. Both have contributed to a crippling of the many elderly services programs which depend on volunteers for their survival.

The Retired Senior Volunteer Program and the Foster Grandparent Program are two programs which require that participants must have some type of transportation. In commenting on a New York RSVP program. Ossofsky said:

> 100 volunteers are now losing money and a large proportion of them are expected to drop out because it is becoming financially impossible for them to continue participating.

B. Nutrition Program

The Nutrition program authorized by the Older Americans Act finally became operational toward the end of 1973. In February 1974 a number of these new projects were forced to curtail operations. The consulting nutritionist for the Maryland Commission on Aging reported:[2]

> The week of February 4, 1974, Garrett County, Maryland was without gas. Because of this it was necessary to close the title VII feeding program for the elderly at the Jennings and Crellin sites. This caused a drop in daily meal census from 102 to 44 for the county including congregate and home delivered. The program depends on volunteers to get participants to the meal sites and to deliever homebound meals.

The Nutrition program has been particularly hard hit by inflation which has been intensified by the energy crisis. Food costs have skyrocketed, heating and electrical costs are on the increase. There are also a number of indirect effects on the program. An example is the use of throwaway plastic food containers. Because most plastic containers are made from petroleum by-products, their cost has increased and they are often in short supply.

III. OVERALL IMPACT ON TRANSPORTATION

Senator Lawton Chiles (Florida), opening hearings on transportation and the elderly in February 1974,[3] said he had not intended to dig deeply at the hearings into the energy crisis.

He added:

> In the weeks since then, however, the committee has received reports indicating that some programs designed to serve the elderly are being shut down or sharply curtailed. Volunteer workers, in some cases, can't find the gasoline they need to reach older people in need of their help. In my home State, the St. Petersburg area seems especially hard hit. Many older persons are, in effect, marooned. Distances are too great

[2] Janette C. Martin, letter dated Feb. 20, 1974.
[3] February 25, 1974, at hearings cited in fn. 1.

for them to walk; gasoline stations are closing; and transportation systems don't meet their needs.

A similar comment was made by Senator Dick Clark (Iowa):

> The lack of energy and the resulting lack of transportation is a nationwide problem, affecting all citizens in every kind of community—urban, suburban, and rural.

Senator Charles Percy (Illinois) said:

> The energy crisis has brought home to each and every one of us the inconvenience, the frustration, and the trauma of transportation deprivation and the crucial role of mobility to the satisfaction of our basic, every day needs. This heightened sensitivity, I hope, will bring forth more vigorous efforts on the part of all of us to assure older Americans and handicapped Americans their right to equality of mobility.

William R. Hutton, executive director of the National Council of Senior Citizens said:

> I have heard older people express hope that something will be done about the transportation dilemma because other people are now also experiencing difficulties in getting from one place to another during this energy crisis. Overall dependency on the private automobile will only be decreased when a desirable and dependable alternative method of getting where we need to go is developed. As less than 50 percent of the people 65 and over are licensed drivers and cannot afford to maintain a car and pay the high insurance premiums, the elderly as a whole cannot depend on the luxury of a private car as their means of transportation. Last week while I was discussing my impatience of waiting in line for over an hour to get gas, one of the older people in the office whose only mode of transportation is a bus, spoke up and said, "Is that any different than having to wait out in the cold or rain on the weekends for one-half to three-quarters of an hour for a bus and then have to wait again to come back? And that has not just happened in the last couple of months." Good transportation systems must be developed for everyone and as the elderly are more transit dependent than most other groups in our society, special emphasis should be placed on their needs.

Administration on Aging Commissioner Arthur Flemming said at the hearing he is conducting a survey to determine the effects of the gasoline shortage on programs to serve the elderly. He was invited to return and make a report at a later hearing.

Dennis Bakke, Executive Assistant to the Deputy Administrator of the Federal Energy Office, said that FEO is establishing a Special Impact Office to consider "the effects of the shortages on the aged and other severely impacted groups."

FINDINGS AND CONCLUSIONS

Some easing of the gasoline and overall shortages has been predicted by some high-level administration officials, while others say that the present problem will be long-range and that it may have new peaks of intensity.

It is essential that the Administration on Aging and other Federal officials pay special heed to damage already done to programs meant to serve the elderly, and that these agencies develop contingency plans for sustaining programs that could be seriously weakened and endangered.

The Department of Labor has a special responsibility. It should develop and apply means of assistance to older workers whose jobs have been curtailed or terminated by the fuel crisis, to assure that the upper age employees do not bear a disproportionate share of employment disruption resulting from fuel cutbacks.[4]

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[4] For additional discussion of older worker problems, see p. 113, ch. VIII pt. III of this report.

CHAPTER VII

THE NEW OLDER AMERICANS ACT

I. INTRODUCTION

The Older Americans Comprehensive Services Amendments of 1973 (Public Law 93–29)[1] represent a significant change in the focus of the Older Americans Act.[2] They provide the basis for a comprehensive coordinated service system for the elderly, specifically in titles III and VII.

Title III authorizes formula grants to the States to create sub-State or area level systems which function to coordinate, link and pool the untapped resources within their boundaries for the elderly. To carry out this strategy, title III strengthens and gives new responsibilities to the States in order to carry out the activities and duties necessary for creating a service system for the elderly. The State must develop a State plan which shows how the State has been divided into distinct geographical areas, planning and service areas (PSA) and which of these areas will be designated to develop area agencies on aging within their boundaries. (Planning and service areas and area agencies on aging are discussed in further detail in later sections of this chapter.) An area agency, in turn, must develop an area plan showing how it will serve as an aging focal point in the community and will coordinate the existing services within their area for the elderly.

The area agency is not intended to provide direct services unless it was doing so prior to its designation as an area agency and these services are considered necessary to assure an adequate supply of services, and, no other agency within that area can provide for and deliver such a service. Approval for an area agency to deliver such services must be given by the State agency.

The nutrition program for the elderly became title VII of the new amendments. Title VII was created[3] as a formula grant program to provide for the establishment and operation of a program which would deliver low-cost meals for persons age 60 and over. Funds under title VII are allotted to the States, which have the responsibility of making grants or contracts to approved nutrition projects within the States which will do the actual serving and delivering of the meals. The projects designated as recipients of title VII funds may serve meals from one site or several depending on how they best can serve their geographical area. Congregate meals, as well as home-delivered meals, are provided for under title VII, and each project must serve 100 hot

[1] Public Law 93–29, 93rd Congress, S. 50, May 3, 1973.
[2] Public Law 89–73, July 14, 1965 as amended by Public Law 90–42 July 1, 1964 as amended by Public Law 91–69, Sept. 17, 1969.
[3] Public Law 92–258, 92d Congress, S. 1163, March 22, 1972.

meals per day, 5 days a week, unless special exemptions are granted by the Commissioner. The law and regulations also require that the nutrition projects must provide for supportive social services, such as outreach, transportation and health services, to be incorporated into the overall system under title VII. Title VII may be aided in support for these services by coordination with title III and title VII may be one of the services coordinated within an area agency under the title III structure.

Title II of the amendments of 1973 provides for the Administration on Aging to be within the Office of the Secretary of Health, Education, and Welfare (HEW); the establishment and operation of a National Information and Resources Clearinghouse for the Aging; and, the appointment of a 15-member Federal Council on Aging.

The Administration on Aging was removed from the Social and Rehabilitation Services of HEW. However, a new Office of Human Development (OHD) was formed within the structures of HEW and the Administration on Aging was placed under the auspices of OHD. The establishment of the National Clearinghouse has been a slow process, as there has been no funding request for its implementation. The Federal Council on Aging nominees are being considered and the Council is expected to be announced in the near future.

Grants for training and research are provided for under title IV. Part C of title IV which provides for multidisciplinary centers of gerontology was not funded. (Details about title IV are discussed in chapter IX.)

Multipurpose senior centers are authorized under title V. The act allows for the acquisition, alteration or renovation of facilities to be utilized as senior centers. No funding was requested for title V.

Title VI provided for the National Older Americans Volunteer Program which would support such programs as the Retired Senior Volunteer Program (RSVP) and Foster Grandparents. However, in October of 1973, the title was repealed by the Domestic Service Act which reauthorized these volunteer programs and incorporated into one law the legislative authority for all such programs under the auspices of the independent agency, ACTION. Under ACTION, RSVP received a budget estimate of $15,000 for fiscal year 1974 and Foster Grandparents received $25,000.

Library Services and Construction Act was authorized by title VIII. This title would allow for grants to be made to make library facilities and services more available to the elderly. No funding was requested for title VIII.

Title IX established an Older Americans Community Service Employment Program which would aid persons 55 years or older in securing employment. The Senate had approved $40 million for this program but the amount was cut back to $10 million when the final supplemental appropriations bill for fiscal year 1974 was approved. (Title IX is discussed further chapter VIII.)

II. THE NEW STRATEGY BECOMES OPERATIVE

The enactment of the new amendments and the implementation of the new programs brought almost immediate problems to the State agencies on aging. Administrative complications, lack of

coordination, relatively small staffs and lack of direction created obstacles to any measurable progress that could be recorded for the year. The analysis and planning period which should precede any such program was shortened and may have been confused by pressure upon the agencies to deliver services. Disagreement over designations of planning and service areas (PSA) and area agencies on aging added to circumstances affecting the implementation of the programs.

A. Title III

Final regulations for title III were published on October 11, 1973, after great controversy was expressed over the proposed regulations. At a special executive hearing on September 17, 1973, Dr. Arthur Flemming, Commissioner of the Administration on Aging, listened to testimony presented by local, State and project administrators. Comments alluding to the narrow scope of services allowed under the proposed regulations, strict definition of low income, lack of local involvement, and stringent focus of the regulations on planning were discussed with Dr. Flemming. Several suggestions from witnesses were incorporated into the final regulations.

With the issuance of the final regulations, States were faced with the task of drawing up title III State plans by mid-December. Limited staffs were called upon to divide the States into planning and service areas, designate area agencies within certain planning and service areas, and demonstrate the strategies for carrying out the title III programs. Difficulties arose with the designation of area agencies as many existing service programs for the elderly were overlooked and conflicting grantees of title III and VII were appointed. Area agencies found great difficulties in drawing up their required area plans for a comprehensive and coordinated service delivery system because of the lack of services to coordinate.

Many of the existing services within the communities had been supported by Model Cities and Office of Economic Opportunity grants and with these programs facing extinction, a grave shortage of services became realistic. Therefore, title III's chief proponent to "coordinate" became a challenge as services were scarce.

By March 1 some 145 area agencies on aging had become operative, with the administrative projecting that 400 would be operating by June 1974.

B. Title VII

The very late fiscal funding for 1973 [4] put the States in the position of making contracts and obligations of all of their title VII allotment by the end of December or losing that proportion unobligated to other States for reallotment. Therefore, many States were forced to make hasty decisions about project designations and the awarding of contracts. In many areas, planning and development periods were pushed aside as a result of administrative pressures to get meals on the table as soon as possible.

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[4] The supplemental appropriations bill (Public Law 93-50) which included funding for title VII, was not signed into law until July 1, 1973.

Regulations published on September 11, 1973, allowed exemptions of 90 days or more to be made to projects which could not comply with specific staffing and supporting social services requirements as specified in the final title VII regulations (August 19, 1972). These exemptions and the hasty preparation of meals, were a catalyst for many complaints about the program being only a "soup kitchen" or "bread line." The lack of social services continued when the 90 day exemptions were extended for some programs. Complaints about the soup kitchens intensified as certain projects failed to comply with congressional intent.

With inflation and rising food costs burdening the Nation, title VII programs were forced to decrease the number of meals to be served and curb outreach and transportation services. The program which was originally designed to serve 250,000 people was cut back to serve approximately 200,000 because of increases in food prices.[5]

Meals-on-Wheels programs, which depend on volunteer drivers and automobiles, were forced to curb their programs to even discontinue them because of high costs of gasoline. Escalating food prices caused many congregate sites to use the large proportion of their allotment for food, leaving little for supportive social services—such as transportation, health care, and outreach. Such concentration on the food content of the program gave added emphasis to the "soup kitchen" complaints.

Faced with the difficulties of food prices, the energy crisis and needs of the elderly, Congress was challenged to extend the nutrition program whose original legislative authority ends in fiscal year 1974. Senator Kennedy and Congressman Pepper introduced legislation (S. 2488 and H.R. 10551) which would extend the program for 3 more years at increased authorization levels. During hearings held in February by the House Select Subcommittee on Education, Dr. Flemming stated the administration's opposition to the 3-year extension and recommended that only a 1-year extension be approved, to provide "the opportunity of considering simultaneously our operating experiences under both titles III and VII." [6] Testimony by State and title VII project directors disagreed with the administration's position, and they recommended that the 3-year extension be approved to guarantee congressional backing of the program and assure State and local programs that they would not be left "holding the bag." [7]

The subcommittee as well as the full House Education and Labor Committee responded by approving the 3-year extension at increased levels for fiscal years 1976 and 1977 at $200 million and $250 million respectively. The bill was approved by the full House on March 19, 1974.

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[5] The Administration on Aging estimates that the cost of the average meal under Title VII increased from an original estimate of $1.54 per meal to approximately $2.00 per meal.
[6] Testimony presented before House Select Subcommittee on Education, Feb. 13, 1974.
[7] Testimony presented before House Select Subcommittee on Education, Feb. 13 and 14, 1974.

C. PSA's and AAA's

Under title III law and regulations, the State agency must divide the State into specific service areas after taking into consideration such factors as the distribution throughout the State of service needs and service resources, the boundaries of planning areas or areas for the delivery of individual service programs, the location of units of general purpose local governments, and the distribution of elderly throughout the State. These areas, known as planning and service areas or PSA's must be designated before the States can designate specific aging programs or nutrition projects. Any local government unit having a population of those 60 and over which amounts to 50,000 or 15 percent of the State's population aged 60 and over may be designated as a PSA. A State may apply to have itself designated as the sole PSA, but such application must be approved by the Commissioner.

The area agencies on aging or AAA's are the single agencies designated by the State agency to be the focal point or agencies responsible for developing the comprehensive and coordinated service programs for the elderly within specific areas. After the State has designated PSA's, it will determine which of these areas will be "priority areas" which will be designated for the purpose of developing area plans on aging. In each of these priority areas, an area agency on aging will be established. The regulations state that in order to be designated as an area agency, the organization in question must be:

(1) An established office of aging which is operating within a designated planning and service area; or

(2) Any office or agency of a unit of general purpose local government which is designated for this purpose by the chief elected official or officials of such unit; or

(3) Any office or agency designated by the chief elected official or officials of a combination of units of general purpose local government to act on behalf of such combination for this purpose; or

(4) Any public or nonprofit private agency in a planning and service area which is under the supervision or direction for this purpose of the designated State agency and which can engage in the planning, coordination or provision of a broad range of social services, within such planning and service area.[8]

It is the responsibiilty of this designated area agency on aging to assess the market of services available within its jurisdiction and become the "broker" or coordinator of these services. The area agency is directed not to provide direct services itself (although exceptions may be approved by the State agencies) but must set forth a plan which shows how the agency will pool and link together the existing resources for the elderly within its boundaries. The area agency under the auspices of the State agency on aging has the authority directly or through the awarding of contracts or grants to provide for and establish a comprehensive and coordinated service system for the elderly.

[8] Federal Register, vol. 38, No. 196, Oct. 11, 1973, p. 28049, subpt. F, § 903.63(c)(1-4).

III. THE NEW CONCEPT—QUESTIONS

> The time has now come in America to reverse the flow of power and resources from the States and communities to Washington, and to start power and resources flowing back from Washington to States and communities, and more important, to the people all across America.[9]

In describing this method of redelegation of authority within our governmental structure, President Nixon in his State of the Union Message in 1971 gave roots to what has become known as the "new Federalism." In simple terms, the major thrust of the new Federalism assertedly is to return authority to that level of government closest to the people, authority including more State and local power over Federal moneys. The intentions are honorable but the reality of the matter is the big question—will the State and local communities receive enough money to sustain current Federal programs?

Revenue sharing was the tool instigated to cover the cost of such Federal programs. However, many areas, particularly those in the field of social services have been almost totally ignored in the request for funds. According to the Office of Revenue Sharing, only 3 percent of revenue funds were directed to social services for the poor and aged.[10] Therefore, many areas face the problem of finding support from State and local sources to continue past federally supported programs. To date, Revenue Sharing has been essentially a mechanism to channel funding largely for urban community development, reduction of property taxes, and improvement of streets.

A. Are Area Agencies Feasible?

The concept of area agencies on aging is consistent with current administration attempts to decentralize the administration of aging programs, including the authorities over title III. The law (Public Law 93–29) which created the area agencies and gave more power to the community levels also authorized that State units on aging as the existing structures within the States should be strengthened. However, since the enactment of the law, questions have arisen about the levels of aging authorities and the concept of area agencies on aging. These questions include:

—Has the emphasis of strengthening State units on aging been disregarded.

—Can an area agency on aging concept of coordination of services be ascribed to all the States with such diverse service systems existing within many?

—Has the area agency concept been more detrimental than advantageous in that States have been forced in some cases to "reorganize" service systems that had been serving their elderly quite efficiently and effectively?

—What is the answer to coordinating all of the existing sources of

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[9] State of the Union Message, President Nixon, Jan. 22, 1971.

[10] Revenue Sharing: The First Actual Use Reports, prepared for the Office of Revenue Sharing, Department of Treasury, March 1, 1974.

services for the elderly—is it the block grant formula or the allied services method? [11]

—With the implementation of the Supplemental Security Income program,[12] is it feasible to think in terms of a complete "cash-out" program for the elderly?

With renewal legislation coming up in fiscal year 1975 for title III, serious consideration will have to be given to these questions over the next year. As the title III concept develops more significantly, special attention will be given to the relationships of State agencies and area agencies, the effectiveness of coordinated service systems within the PSA's and States, and special attention will be given to the levels of authority within the structure and how they can best serve the elderly. Emphasis of consideration will also be given to the concept of area agencies on aging versus the concept of areawide model projects. Can the areawides created under the 1969 amendments to the Older Americans Act [13] be more effective in serving the elderly than the present programs? Some contend that awarding the States grants to conduct such innovative programs as allowed under areawide model project regulations is a more realistic and productive method of providing services than the "rigid" regulations governing title III. Before renewing title III and other parts of the Older Americans Act, the Congress must carefully consider what service system structure will most effectively serve in the midst of the governmental systems and organizations that now exist.

FINDINGS AND RECOMMENDATIONS

The passage of the Older American Comprehensive Services Amendments must be strengthened by adequate funding before the true effectiveness of the amendments can be measured.

- **The establishment of the Federal Council on Aging as described by the amendments of 1973 must be finalized so that responsibilities of that Council as stated in section 205 of the act may be undertaken.[14]**
- **The committee urges that a careful study be made of the volunteer aging programs under the auspices of ACTION to ascertain if the programs could not be better developed and implemented under the Older Americans Act and the Administration on Aging.**

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[11] Block grant formula would allow each State to receive a single allotment of funds to be used by the States to set up their own type of service system. The allied services approach is a method by which all human services would be integrated into a single program in order to attempt a more effective system. Legislation (S. 3054 and H.R. 12285) have been introduced in the 93d Congress and would create an allied services program.

[12] See ch. I for SSI details.

[13] P.L. 91–69, September 17, 1969.

[14] President Nixon submitted 14 nominations to the Senate on March 27 to be members of the Federal Council on the Aging: Bertha S. Adkins (former Under Secretary of HEW); Dorothy L. Devereux (former member, Hawaii State House of Representatives); Carl Eisdorfer (past president, Gerontological Society); Charles J. Fahey (vice president, American Association of the Homes for the Aged); John B. Martin (former U.S. Commissioner on Aging); Frank B. Henderson (deputy director, Armstrong County Community Action Agency, Worthington, Pennsylvania); Frell M. Owl (member, Indian Advisory Council, U.S. Senate Special Committee on Aging); Lennie-Marie P. Tolliver (professor, School of Social Work, University of Oklahoma); Charles J. Turrisi (member, National Association of Retired Federal Employees and American Association of Retired Persons); Nelson H. Cruikshank (president, National Council of Senior Citizens); Sharon M. Fujii (doctoral candidate, Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University); Hobart C. Jackson (chairman, National Caucus of the Black Aged); Garson Meyer (president emeritus, National Council on the Aging); and Bernard E. Nash (executive director, National Retired Teachers Association-American Association of Retired Persons).

CHAPTER VIII

IMPROVING THE AGE DISCRIMINATION IN EMPLOYMENT LAW AND OTHER MANPOWER LEGISLATION

In fiscal 1973, the U.S. Department of Labor found almost 15,000 American workers between the ages of 40 and 65 to be victims of age discrimination.

More than 2,900 business and manufacturing establishments were found to be in violation of one or more of the provisions of the Age Discrimination in Employment Act (ADEA).

The Department states that enforcement of ADEA is one of its highest priorities, yet a working paper prepared for the Committee noted that the dollars and manpower devoted to ADEA enforcement is strikingly small considering the nationwide scope of the act and its complexity.[1]

In addition, millions of workers are still unprotected by ADEA. This serves to weaken enforcement and educational efforts.

I. A STATUTE IN NEED OF STRENGTHENING

The ADEA became law December 15, 1967 (P.L. 90–202). It protects individuals at least 40 years of age but less than 65. It prohibits discrimination in employment because of age in hiring, job retention, compensation, promotions, and other conditions and privileges of employment. Employers and labor organizations with 25 or more employees are covered as are employment agencies serving covered employers. Federal, State and local employees are not covered.

Certain exceptions are allowed to the prohibitions in the law:

- Where age is a *bona fide* occupational requirement reasonably necessary to the particular business.
- Where differentiation is based on reasonable factors other than age.
- To discharge or discipline an individual for good cause.
- To comply with the terms of any *bona fide* seniority system or employee benefit plan such as a pension, retirement or insurance plan which is not a subterfuge to evade the purposes of this act, except that no employee benefit plan shall excuse the failure to hire an individual.

[1] *Improving the Age Discrimination Law*, a working paper prepared for use by the Senate Special Committee on Aging, September 1973, 44 p.

A. Enforcement

The investigations and enforcement provisions of ADEA followed those of the Fair Labor Standards Act and are administered in the Wage and Hour Division, Employment Standards Administration of the Department of Labor, which also enforces the FLSA provisions.

Enforcement of ADEA is a small part of the activities of the Division which also cover minimum wage and overtime laws and equal pay. In both staff and expenditures, the enforcement of ADEA represents less than five percent of the total.

In fiscal 1969 there were only 46 positions allotted to the new nationwide program launched against age discrimination. Although $3 million was authorized to be appropriated, only $500,000 of this sum was utilized. Today, 5 years later, there are only 69 positions for fiscal 1974 and less than $1.5 million budgeted. In the regions, furthermore, there are no specific individuals assigned to ADEA. Instead, the man hours authorized by the budgeted positions are allocated among the compliance officers working on ADEA cases.

Despite the inadequacy of resources available in enforcing ADEA, the Labor Department has successfully conciliated many cases and has won a number of important court decisions.

Nevertheless, progress has been slow and public awareness of the problem of age discrimination is much less than that concerning the laws against race and sex discrimination in employment. Part of this lack of progress can certainly be assigned to the lack of adequate enforcement resources.

B. Incomplete Coverage

Today only about 50 percent of all workers aged 40–64 are protected under the provisions of the age discrimination law. Employers with less than 25 employees are exempt as well as Federal, State, and local government employees.

Thirteen million persons age 40–64 are estimated to be working in establishments with less than 25 employees and are not covered by ADEA. Some of these are covered by State laws, but others are not. The small business exemptions under State laws vary widely with some having no exemptions; others exempt employers of less than 25 employees or 12, or 8, or 4, or 3.

About 13 million persons are employed by governmental units at the various levels and about 5.5 million are estimated to be 40–64. Some State and local employees are covered by State laws. Federal employees are covered only by Executive Order 11141, February 13, 1964, which declares a public

policy against discrimination on the basis of age. Those covered are Federal employees and persons employed by contractors and subcontractors engaged in the performance of Federal contracts.

While it is the *policy* of the Federal Government to oppose age discrimination, there is no mechanism to root it out. Those who may feel that they have been discriminated against have little recourse. And there is recurring evidence that age discrimination does exist. A report prepared for this Committee last year entitled *Cancelled Careers: the Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees*,[2] found some evidence of such discrimination. It found that in certain instances older employees had been singled out for reduction-in-force action; that the emphasis on early retirement placed an unequal burden on middle-aged workers; and in certain training programs youth is emphasized in determining eligibility

There is also evidence that, like the corporate world, government managers also create an environment where young is somehow better than old.

The Civil Service Commission, for example, in requesting legislation authorizing early optional retirement during reductions-in-force stated:

> Another benefit to be derived from the proposed legislation is that it will enhance the agency's future effectiveness in carrying out its mission by helping to retain younger employees. Nothing raises the average age of an organization more quickly than a substantial reduction in force in which the youngest employees with the lowest retention standing are separated and the oldest employees are retained.[3]

II. ADEA AMENDMENTS UNDER CONSIDERATION

The Fair Labor Standards Amendments of 1973 included amendments to the ADEA which would have:[4]

1. Increased the authorization for funding from $3 million to $5 million.
2. Extended coverage to Federal, State and local government employees.
3. Extended coverage to employers with 20 or more employees.

The Senate-passed legislation included these amendments but they were deleted in conference committee because of the House germane-

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[2] U.S. Senate, Special Committee on Aging, *Cancelled Careers: the Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees.* A report to the Special Committee on Aging, 92d Cong. 2d Session, Committee Print, May 1972, 43 p.

[3] U.S. Senate, Committee on Post Office and Civil Service. *To permit immediate Retirement of Certain Federal Employees.* 93d Cong. 1st Sess. Report No. 93–152, May 15, 1973, p. 5. The Congress subsequently passed legislation (H.R. 6077 and S. 1804) which implemented the recommendations of the Civil Service Commission. This proposal was later signed into law (P.L. 93–39) by President Nixon on June 12, 1973.

[4] The amendments included in the legislation by the Senate Committee on Labor and Public Welfare were based on legislation introduced by Senator Church and by Senator Bentsen.

ness rule. Subsequently, the Fair Labor Standards bill was vetoed by the President.

In the second session of the 93d Congress, the Senate Committee on Labor and Public Welfare again included the Amendments in the Fair Labor Standards legislation which was passed by the Senate. This time the House Education and Labor Committee included the ADEA amendments in the companion legislation and they are expected to become law barring Presidential veto.[5]

III. MANPOWER LEGISLATION

Two measures enacted in 1973 will affect Federal manpower programs for older workers.

One is Title IX of The Older Americans Comprehensive Services Amendments of 1973 and the other is The Comprehensive Employment and Training Act of 1973. Both laws authorize funding for Operation Mainstream type of projects for older workers which were formerly authorized under Title 1–B of the Economic Opportunity Act of 1964.[6]

A. Title IX—Community Service Employment for Older Americans

This title authorizes the Secretary of Labor to establish a program "to foster and promote useful part-time work opportunities in community service activities for unemployed persons who are fifty-five years old or older and who have poor employment prospects . . ." The Secretary is authorized to pay 90 percent of the cost of any project.

The Supplemental Appropriations bill for the Department of Labor for fiscal 1974 provided $10 million to start this program. Currently the Operation Mainstream programs are being operated under prior authorization.

B. Comprehensive Employment and Training Act of 1973

A major realignment of manpower and training programs is authorized by this legislation for it decentralizes the programs and adopts the revenue sharing approach. Also included is an extension of the Emergency Employment Act in Title II—Public Employment Programs.

The manpower services program will be administered through designated prime sponsors (States, cities, counties) and is expected to be in operation by July 1, 1974. In order to receive funds, each prime sponsor will prepare its own program goals and statement. If the program statement meets the provisions of the law, the Secretary must provide the financial assistance. The Federal Government will no longer approve or disapprove individual projects.

Among the projects which may be sponsored are Mainstream programs to provide job opportunities for older workers. Also authorized are "special services for middle-aged and older men

[5] Enacted into law April 8, 1974, Public Law 93–259.
[6] See appendix item 10, p. 258, for description of Operation Mainstream.

and women including recruitment, placement, and counseling for such who are unemployed as a result of the closing of a plant or factory or a permanent large-scale reduction in the work force of a locality . . ."

In addition to the services and job opportunities for older workers which may be elected by prime sponsors, the Secretary of Labor may also provide such services to older workers.

The Public Employment Programs section of the law provides transitional employment in public service jobs for unemployed and underemployed persons in areas of substantial unemployment. The latter is defined as any area which has had an unemployment rate of 6.5 percent for three consecutive months.

Special consideration is to be given persons who are the most severely disadvantaged in terms of the length of time they have been unemployed. This provision should be of assistance to older unemployed workers since typically older people, particularly those over age 55, remain unemployed longer than younger people.

FINDINGS AND RECOMMENDATIONS

It is apparent from a review of progress to date under the Age Discrimination in Employment Act that a great deal remains to be done to wipe out this particularly insidious form of discrimination.

The dollars and manpower devoted to ADEA enforcement is insufficient to enforce an act that is nationwide in scope and covers some 800,000 establishments. Additional resources must be committed to the objectives of the act. The Administration is urged to request the authorized amount for administration of ADEA.

Only about 50 percent of all workers aged 40–65 are covered by ADEA. The protection of the act should be extended to State, local, and Federal employees and to workers in establishments which employ 20 or more employees.

The legislation in the Older Americans Act to provide community service employment for older Americans should be implemented as soon as possible to carry on the work of the successful Operation Mainstream programs formerly funded under the Economic Opportunity Act.

States and localities are urged to implement the programs for middle-aged and older workers authorized by the Comprehensive Employment and Training Act of 1973.

While the manpower revenue sharing legislation provides an opportunity to maintain and even increase manpower programs for older workers, continuing review is needed to determine if enough resources are indeed being diverted to the needs of older workers.

CHAPTER IX

RESEARCH AND TRAINING

I. INTRODUCTION

Over the last few years there has been an awakening attitude in the field of aging as the older population continues to grow, as services for the elderly considerably increase, and, as the Congress and Administration recognize their responsibility to the country's aging.

However, as the number of elderly continues to grow so grows the gap between the services and the number of personnel to man these programs.

A dearth of trained personnel in the field of gerontology impelled the Congress to include in the Older Americans Comprehensive Services Amendments of 1973 specific commitments to broaden the range of training opportunities through the Administration on Aging. Yet, in requesting the budgets for fiscal year '74 and fiscal year '75, the President made no provisions to continue training for aging under the Older Americans Act and other existing sources of funding within the Department of Health, Education, and Welfare.

Moreover, the Administration further weakened the support for training programs by proposing that the funds appropriated by Congress for aging training in fiscal year '74 would be divided over a two-year period and would be used for support of short-term or in service training courses only.

The suddenness of the Administration's decision to phase out the funds earmarked for training in the field of aging caused alarm and frustration to universities and gerontological centers across the United States who were faced with a withdrawal of support and, therefore, a severe weakening and often a complete eradication of their aging programs. The gerontologists argued that there had been no "authoritative manpower study" to demonstrate that the number of persons engaged in the field of aging research, training, and service is adequate. Moreover, there is evidence to show that personnel trained in the field is in very short supply. Such evidence is shown by this chart which projects the need in the next 5 years for more trained personnel.

PROJECTED TRAINING NEEDS[1]

	1973	1978	Newly trained	New positions	Attrition
Small area planning	300	1,500	1,400	1,200	200
State planning and administration	500	1,250	1,000	750	250
Nutrition project directors	275	3,000	3,225	2,725	500
Managers, retirement housing	8,200	27,000	20,800	18,800	2,000
Senior citizen directors	3,000	3,800	1,800	800	1,000
L.P.N. (nursing homes)	88,000	113,000	50,000	25,000	25,000
R.N. (nursing homes)	73,000	81,000	16,000	8,000	8,000
Physical therapists (aged)	3,300	6,600	3,900	3,300	600
Recreation leaders and specialists	25,000	42,000	24,000	17,000	7,000
Teachers at colleges, universities, community colleges	500	2,100	1,700	1,600	100

[1] These projections are based upon (a) updated estimates from the study on "The Demand for Personnel and Training in the Field of Aging" (conducted by Surveys and Research Corp. in 1968), (b) figures from the Office of State and Community Planning at the Administration on Aging, and (c) studies conducted by the National Association of Housing and Redevelopment Officials and the National Recreation and Park Association.

Yet, the Administration continues to insist that no specialized training, or "categorical programs" of any kind shall continue in institutions of higher education.

II. CATEGORICAL VS. NON-CATEGORICAL

The Administration contends that the goals for planned expansion of specialized manpower in many fields of medical and scientific research have been reached and that the law of supply and demand will now compensate to produce the needed manpower in these areas. Through the implementation of "non-categorical student aid programs" the Administration argues that the person who seeks a higher education is given more choice of freedom to choose the field and place of study he desires. Therefore, by phasing out the "narrow categorical training programs" and creating "non-categorical basic opportunity grants" the student is given the discretion to make career choices among certain categorical areas without regard to the financial inducements associated with the specialized categorical programs.

However, the field of aging is "fragile" in the sense that it is relatively new to colleges and universities and oftentimes is multi-disciplinary in scope. Aging programs do not have the roots of support in academia when compared to other areas of discipline and henceforth are at a disadvantage when compared to long established, single disciplinary programs when resource allocations are under consideration. Underdeveloped and dispersed programs which have been groping for stability and recognition are faced with the ultimatum of somehow attracting students to the field or being cut from the institution's curriculum because of the lack of student interest.

The Administration's contention that the student will be able to choose his field of study and that the law of supply and demand will suffice to produce the needed personnel in the field does not hold true in the field of aging. Service to the aging is still unknown to many incoming students. Therefore, incentives for students to enter the field of aging are considerably diminished when they are not initially attracted to the field by the availability of financial support. Many students have stated that the funding support precipitated their interest

in aging which soon became active and intense.[1] The Administration's stand is particularly confusing when reading their evaluation of the AoA traineeship grant program, which shows that 92 percent of the trainees indicated that the AoA grant was a deciding factor in their choice of aging as a field of study (see appendix 1, item 2, p. 235). If this attraction is lost, the aging programs will be seriously jeopardized as the core of any program is the students who determine the program's status within the institution's curriculum.

III. CONGRESSIONAL ACTION

The Administration's proposal to cease all categorical training programs, including those authorized under the Older Americans Act, prompted the Committee on Aging at the suggestion of Senator Lawton Chiles to conduct a survey of gerontological programs across the country. The survey was structured so as to assess the effectiveness of the institution's aging program and the implications the Administration's proposal would have on their future.

The response to the survey was overwhelming and clearly demonstrated that the termination of such funds would seriously affect the overall supply of trained personnel in the field of aging.

In June of 1973, Senator Chiles further explored this alarming situation by holding 2 days of hearings on "Training Needs in Gerontology" before the Special Committee on Aging. Testimony presented over the 2 days clearly reinforced the evidence from the survey which showed the value of the programs and their effectiveness in producing more trained personnel in the field of aging. The witnesses agreed that not only would the phasing out of funds be a detriment to the aging programs and the number of personnel in the field; but, would promote the failure of the institution in attracting second career students who make up a large percentage of the programs; curtail the capacity of the institution in giving technical assistance to the developing community aging programs; and, cause a set-back to the general accumulation of aging knowledge.

Assistant Secretary for Legislation at HEW, Stephen Kurzman, testified that the Administration recognized the "continuing and increasing demand for persons who have completed both undergraduate and graduate programs in the field of aging."

However, Mr. Kurzman went on to say that the Administration's proposal to replace the "narrow categorical training programs" with a general student aid program would be ample assistance in supplying adequate support for training programs in aging.[2] Mr. Kurzman's assumptions were challenged by many of the other witnesses including the renowned educator in the field of aging, Dr. Wilma Donahue, past Director of the Institute of Gerontology of the University of Michigan and Staff Director for Post Conference Board of White House Conference on Aging. Dr. Donahue stated that:

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[1] See "Training Needs in Gerontology," hearings before Special Committee on Aging, Parts I and II, June 19 and 21, 1973.

[2] Testimony before the Special Committee on Aging, June 21, 1973.

> The 36 training programs now receiving support from the Older Americans Act are on an average less than 5 years old. They are, thus, especially vulnerable to erosion, and elimination, and particularly so when in competition with other professional fields. Social work, public health, education and medicine and so on have the advantage of a long history; hence, they have the prerogatives and strengths of high seniority.[3]

Walter M. Beattie, Director of the All-University Gerontology Center at Syracuse University, echoed Dr. Donahue's concern:

> This withdrawal of training support is occuring at the same time that the Congress and the President have expressed their commitment to expanding services to older persons through the Older Americans Comprehensive Services Amendments of 1973. These amendments have also continued to recognize the need for the support of training and research, as well as of gerontology centers. As areawide agencies on aging and services for the aging are being expanded, the capacities of training programs in aging to respond to the increased manpower requirements of community, regional, and State programs for older persons are being reduced or eliminated.[4]

With the information gathered from the survey of gerontological centers and from the 2 days of hearings, Senator Chiles appeared before the Subcommittee on Labor-HEW Appropriations of the Senate Appropriations Committee to testify as to the need for continuing the funding for training programs under the Older Americans Act. His efforts were heeded and the Senate, as well as the House of Representatives, included provisions for training under Title IV, Part A of the Act. This funding amounted to approximately $9.5 million (after 5% authorized withholding) when the final Labor-HEW Appropriations Bill (P.L. 93-192) was passed and signed into law.

However, upon issuing the budget request for fiscal year 1975 the Administration ignored the intent of Congress and specified that the $10 million appropriated by Congress for the purpose of supporting training as defined under Title IV, Part A, would only be awarded for the support of short-term training courses for both fiscal year 1974 and fiscal year 1975.

Thus, gerontological programs whose major support came from training grants from the Administration on Aging were faced with the possibility of receiving only small grants for the purpose of developing in-service programs for the training of personnel to man the many service programs for the elderly.

In response to this alarming news, the Senate Committee on Aging was invited by the House of Representatives' Select Subcommittee on Education to participate in a segment of the subcommittee's hearing which would discuss the ramifications of the Administration's proposal. In a letter to Chairman Brademas of the Select Subcommittee, Senators Church, Chiles, Williams, and

[3] Testimony before Special Committee on Aging, June 21, 1973.
[4] Testimony before Special Committee on Aging, June 19, 1973.

Eagleton expressed their dismay over the Administration's action and stated that "it was an obvious and clearcut violation of the intent of Congress and urge that the Administration reconsider its position."

Gerontology was represented at the hearing by Mr. Beattie and Mr. Wayne Vasey testifying on behalf of the Association for Gerontology in Higher Education. Mr. Beattie pointed out that "through the decisions of the present Administration, universities and colleges are caught in the dilemma of honoring their contractual obligations to such (gerontological programs) faculty and students, while at the same time the Federal government is not honoring its contractual obligations to institutions of higher learning." [5]

In assessing the relationship of the Administration's proposal to the overall gerontological field, Mr. Vasey stated that the probable result would be the elimination or severe curtailment of many or most of the programs. "But perhaps the saddest part of the picture," stated Mr. Vasey, "is the apparent disregard of the tremendous surge of interest in aging on the part of many graduate and undergraduate students on many campuses. All institutions report the same phenomenon of increased interest and demand from students." [6]

IV. UNCERTAIN FUTURE FOR NICHD

Research in aging concerned with the medical, biological, and behavioral aspects of aging are conducted and supported by a division of the National Institutes of Health, the National Institute of Child Health and Human Development (NICHD). Being an institute concerned chiefly with child health problems, NICHD spends only about 10 percent of their total budget on aging research. Therefore, the chief center for aging research within the health programs (Adult Development and Aging Branch) spent only $12,336 for aging research in fiscal year 1973 and only $11,838 for fiscal year 1974.[7] Less than one-tenth of 1 percent of all Federal expenditures on health programs is spent on nearly 22 million persons age 65 and over.

NICHD's future is facing uncertainty as phase-outs and cuts begin to be implemented. NICHD's total budget request has been decreased from the last fiscal year's budget which has caused considerable alarm to institutions involved in aging research. Continuation budgets, as well as basic research grants, have been drastically cut as the Administration carries out the proposed cutbacks in the field of medical research.

Dr. George Maddox, Director of the Center for the Study of Aging and Human Development at Duke University, commented:

> We argue that our estimates of immediate and long-range need for trained manpower in aging indicate the need for an increased, not a decreased, investment at this time. Efficient, effective services for the elderly will not be insured by reduction of support for research and training. The contrary is

[5] Testimony given before the House Select Subcommittee on Education, February 13, 1974.
[6] Testimony given before the House Select Subcommittee on Education, February 13, 1974.
[7] Information provided to Special Committee on Aging in a letter from Dr. Gerald D. LaVeck, Director, National Institute of Child Health and Human Development.

> true. Adequate appropriations, particularly for training, must be insured for both NICHD and AoA."

Dr. Maddox goes on to say that he estimates that nearly $16 million could be spent responsibly in fiscal year 1974 by NICHD.[8]

The need for a centralized agency pertaining to aging research is recognized by members of the Congress. Senator Eagleton re-introduced legislation (S. 775) in February 1973 which would create a National Institute on Aging. Such an institute would provide for a coordination between various aspects of aging research and act as a bridge between efforts. A National Institute on Aging, which was recommended by the White House Conference on Aging, was passed by the last Congress and later vetoed by the President. The Administration argues that such an institute would create "duplication of efforts" and would not "itself foster aging research." [9] The Congress contends that such an institute would benefit the field of aging and in line with this belief, the Senate passed S. 775 overwhelmingly. The bill (H.R. 65) is now awaiting action in the House of Representatives.

V. RESEARCH—WORTH THE INVESTMENT?

Over the past decade the area of knowledge concerning the aging process has substantially increased. Methods of extending the longevity of the elderly as well as keeping them free from institutional care have been tried and researched and many have been found to be successful. Services such as nutrition, public housing, home health, and transportation have been implemented as a result of years of research and demonstration projects and are the basis for building many of the service programs now operative under the Older Americans Act. Although productive, the research has been done in conditions warranting support, especially in funding. Over the past few years funding for research in aging has been decreased for both NICHD and AoA programs. This has caused alarm as well as major setbacks in the strive for more accumulation of aging knowledge.

Biological, social and behavioral aspects of the aging process have been areas in which the knowledge has increased and produced remarkable results because of specialized research. Information concerning new drugs, description of vitamin deficiency in the elderly, immunological responsiveness in aging humans, aging loss in verbal learning performance, and association of aging with coronary heart diseases are but several of the areas in which research has demonstrated the need for continued and expanded study in this area of undetected knowledge.

The President expressed his views on the importance of research in the area of aging when he said:

> It is important that the same scientific resources which have helped more people live longer lives now be applied to the challenge of making those lives full and rewarding for

[8] Testimony before the Senate Special Committee on Aging, June 21, 1973.
[9] Testimony given by Frank C. Carlucci, Under Secretary of Health, Education, and Welfare before the Subcommittee on Aging of the Labor and Public Welfare Committee, March 27, 1973.

more Americans. Only through a wise investment in research now, can we be sure that our medical triumphs of the past will not lead to social tragedies in the future. What we need is a comprehensive, coordinated research program, one which includes disciplines ranging from biomedical research to transportation systems analysis, from psychology and sociology to management science and economics.[10]

FINDINGS AND RECOMMENDATIONS

In 1974 we witness the increasing numbers of aged persons and strategies to increase the life expectancy while at the same time we witness the decrease in aid for aging training and research. An important obstacle to pass before overcoming this situation is limited knowledge and trained personnel in the field of gerontology. This fact is well recognized. Yet, the field of aging continually faces setback and frustration because of funding cutbacks. With these points so obvious, the Committee recommends:

- **Establishment of a National Institute on Aging which would provide for a central agency in which the biological, social, and behavioral aspects of the aging process could be coordinated.**
- **Funding of Title IV, Part C of the Older Americans Act so that multidisciplinary centers of gerontology may be developed and supported to further advancement in the field of aging.**
- **Adequate funding for Title IV, Parts A and B, so that training and research in the field of aging may be continued and expanded. With adequate funding, there should be the recognition that aging is a "new field" and, therefore, emphasis must be given to see that categorical programs are continued at institutions of higher education where both undergraduate and graduate programs, both long and short term courses, are continued and expanded.**
- **Provide for additional funding for National Institute for Child Health and Human Development (NICHD) so that the Institute may further its research efforts in the field of the aging.**

[10] President's Message on Aging, March 23, 1972, Document No. 92–268.

CHAPTER X

TRANSPORTATION AND OTHER CONSUMER ISSUES

Mention has already been made in this report about the fact that older Americans pay the bulk of their income for food, housing, transportation, and medical care.[1] Inflationary increases, particularly for the cost of food,[2] have been especially oppressive for the aged.

The elderly, who generally live on less than half the income of people still in the labor force, are hard-hit by general rises in living costs. In addition, they face other consumer problems—of the kind discussed in this chapter—which become especially severe in the later years of life.

I. TRANSPORTATION: PROBLEMS AND PROGRESS

Mobility for older Americans represents access to crucially important services and personal contacts.[3] The need for improved transportation opportunities was recognized at the White House Conference on Aging in 1971[4] and in administration statements[5] since that time.

Recent legislative enactments—and one dating back to 1970—have provided authority for Federal action which could help develop transportation resources for the elderly, but progress thus far has been limited.

To examine the current situation, the Senate Special Committee on Aging began a new inquiry at hearings[6] early in 1974. The first round of testimony described promising experiments and new developments, but also yielded several expresions of dissatisfaction with the pace of progress thus far.

A. Scope of the Hearing

Senator Lawton Chiles (Florida) conducted the hearings and said that the Committee on Aging was as much interested in progress as in problems encountered by the elderly in need of transportation:

"Progress," he said, "is still in its early stages, but encouraging. In Florida, for example, State agencies and a university are working together, by means of annual conferences and other efforts, to develop a statewide program for the transportation disadvantaged. Several

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[1] See ch. 1, sec. II: "Major Costs for the Elderly: The Impact of Inflation," p. 9.

[2] From December 1972 to December 1973, the price of food increased by 20.2 percent. For further discussion of the impact of inflation upon the elderly, see p. 13.

[3] See: *Older Americans and Transportation: A Crisis in Mobility*, S. Rept. No. 91-1520, by the Senate Special Committee on Aging, December 1970.

[4] For example, President Nixon told the conference: "We have made . . . administrative decisions which . . . will require that Federal grants which provides services for older persons also provide for the transportation they need to take advantage of these services."

[5] For example, Commissioner of Aging Arthur Flemming, at Senate nomination hearings in May 1973, said: ". . . it does little good to provide services for older persons if those services are inaccessible or unavailable due to poor transportation."

[6] "Transportation and the Elderly, Problems and Progress," Feb. 25, 27, 28, 1974, Washington, D.C.

pilot programs are yielding valuable lessons and providing essential services in some parts of the State. In other States, there are other demonstration projects.

"But all in all, the progress is much too slow . . ."

Senator Chiles said that transportation problems so vigorously discussed at the White House Conference existed in 1971—and still exists—in cities, suburbs, and rural areas. He added:

> Most older persons must rely on public transportation systems—where they exist—to give them the means to reach shops, churches, doctors offices or clinics, and their friends. Foot power . . . is a major means of transportation, at least for those whose neighborhoods are still fairly coherent. But the closing of a single retail store or any other vital facility can change a neighborhood overnight. For many residents, it would be time to move. For many elderly, a move may be impossible.

The Senator also said that one of the major objectives of the hearing would be to examine the progress made under legislative enactments since 1970.

B. What Has Already Been Enacted

Four years ago, Congress adopted an amendment to the Urban Mass Transportation Act which stated:

> It is hereby declared to be the national policy that the elderly and handicapped persons have the same right as other persons to utilize mass transportation facilities and services.

The amendment also gave discretionary authority to use $46.5 million to adapt transit systems for better service to the elderly and handicapped.

An estimate of progress since then was provided at the 1974 hearing by Jack Ossofsky, executive director of the National Council on the Aging:

> . . . In the following fiscal year, a total of only $2.5 million—instead of the expected $46.5 million—was appropriated for the Department of Transportation's Service Development Branch to test out new ways of serving all "transit-deprived" groups, a term which includes not only the elderly, but also the handicapped, youth, and low-income persons of all ages.
>
> It can safely be assumed then that only a fraction of the $2.5 million was specifically directed at the elderly population.
>
> For fiscal year 1974, demonstrations thus far appproved or planned for approval which are specifically designed to serve the aged and handicapped total a mere $1.077 million, although the Department of Transportation budget officer who provided us with this sad figure last week did add that he was not including in this figure other ongoing projects with elderly components contained within them or serving the aged in a less direct way. In any event, it is clear from these ex-

penditure figures that the discretionary clause is not working as we had hoped.[7]

A similar evaluation was given by John Martin, former U.S. Commissioner on Aging and now consultant to the American Association of Retired Persons:

> . . . funding, particularly for projects to modify existing systems to make them more accessible to the elderly and the handicapped, would go a long way toward solving the special transportation of the elderly. However, the Urban Mass Transportation Administration (of DOT) has not exhibited a strong commitment at the present time to this type of capital expenditure and only a limited number of capital grants specifically aimed at the special needs of the elderly and handicapped have been awarded.
>
> Local jurisdictions unfamiliar with the language of the Urban Mass Transportation Act would be unlikely to apply for such moneys since *no specific mention is made of their availability in the information sent to prospective applicants.*[8]

FEDERAL AID HIGHWAY ACT OF 1973 [9]

Congressional action on the Federal Aid Highway Act of 1973 was discussed at the Committee on Aging hearing because it contained several provisions of direct relevance to older Americans.

It broadened the 1970 amendment by increasing the amount that the DOT Secretary can channel to improve and design transit systems for the elderly and handicapped: from 1½ to 2 percent of the amount authorized for the urban mass transportation capital grant program.

Mr. Ossofsky said that the 1974 amendment repeats the mistake of the 1970 amendment:

> Although it included the promising provision that 2 percent of the total $6.1 billion be earmarked for financing programs designed to meet the needs of the elderly and handicapped, the language read only that the Secretary "may" set this enormous amount aside—perpetrating a cruel hoax on the many persons whose hopes have again been raised by falsely believing the dollars are required to be set aside.
>
> NCOA is certain that Congress acted with the best of intentions when it included this provision into the landmark measure. But we have seen, time and time again, that without specific legislative mandates the elderly will not get their fair share. This is as true at the local level, where less than 1 percent of local general revenue sharing funds are being expended on programs for the elderly, as it is at the Federal level.
>
> For this reason, Mr. Chairman, we strongly urge that the discretionary language to the elderly and handicapped in the Urban Mass Transit Act be revised so that specific allocations are mandated and funding assured for elderly transportation programs.

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[7] February 25, 1974, hearing cited in footnote 6.
[8] February 27, 1974, hearing cited in footnote 6.
[9] Public Law 93–87, approved Aug. 3, 1974.

The 1973 Highway Act includes other provisions discussed at the hearing:

—It enables the DOT Secretary to make grants and loans to private nonprofit corporations and associations—a provision which fosters development of transportation subsystems designed to help the handicapped and the isolated elderly.

—It provides for a rural public transportation demonstration program.

—It enables States to use part of highway funding for public transportation purposes.

AN ADMINISTRATION PROPOSAL

A few weeks before the committee hearing, the President issued a message[10] outlining plans for a unified Federal approach to mass transportation assistance.

Benjamin O. Davis Jr., Assistant DOT Secretary for Environment, Safety and Consumer Affairs [11] described provisions of the proposed new Unified Transportation Assistance Act of 1974.[12]

"Section 1808 of the bill," said Secretary Davis, "would direct the Secretary to require that any bus or other mass transportation rolling stock, station, terminal, or other passenger loading facility improved after June 30 with Urban Mass Transportation or Federal-Aid Highway funds, be designed with practical and reasonable features which allow their utilization by elderly and handicapped persons."

He added:

> We believe this explicit statutory requirement, which will be common to mass transportation projects financed from either UMTA or highway funds, will help us to meet the congressional intent of mobility for the elderly set forth in current statutes, while providing greater flexibility to local officials as to the best means for meeting these goals in light of local situations.

Senator Chiles, however, had raised several questions about the administration unified mass transportation bill in a letter of February 25. The Senator said that he was concerned about the possibility that the administration bill, as written, would encourage the development of small, token transportation subsystems to be established to deal with the needs of "a vocal few handicapped and elderly."

Secretary Davis said at the hearing:

> I want to assure you, Mr. Chairman, it is not the intent of this department to permit this sort of token compliance. It is, on the other hand, our purpose to provide greater flexibility to local officials to meet the genuine needs of the elderly and handicapped in light of local circumstances.[13]

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[10] President's Transportation Message. Cong. Rec. Vol. 120, Monday, Feb. 18, 1974, No. 17, p. D103.

[11] February 28, 1974, at hearing cited in footnote 6.

[12] Statement by Benjamin O. Davis Jr., Assistant for Environment, Safety, and Consumer Affairs, Department of Transportation before Senate Special Committee on Aging, February 28, 1974.

[13] For the complete text of the Senator's letter and the Secretary's commentary at the hearing. See appendix to hearing cited in footnote 6, Feb. 28, 1974.

Congress in 1973 considerably broadened the functions of the U.S. Administration on Aging by enacting the Older Americans Comprehensive Services Amendments of 1973.[14]

Special attention was given to transportation in those amendments. Study and demonstration projects related to transportation.[15] In addition, the amendments directed the Commissioner on Aging to conduct a survey which would emphasize "solutions that are practicable and can be implemented in timely fashion."

Senator Chiles, in his opening statement at the hearing, said:

> The Commissioner is to consult first with the Departments of Transportation and Housing and Urban Development, and he is to give careful attention to the possible usefulness of *all* components of public transportation systems.

The Senator also expressed his disappointment that the administration had not requested funds in the proposed fiscal year 1975 budget for the survey or the demonstration projects.

The potential importance of the survey was described by former AoA Commissioner Martin:

> . . . Such a study could serve as the basis for a coordinated national approach to meeting the transportation needs of older persons. Unfortunately, no action has been taken on section 412 during fiscal year 1974, and it is our understanding that no funds have been earmarked for implementation of this section during fiscal year 1975.

The present AoA Commissioner, Dr. Arthur Flemming, also discussed section 412:[16]

> The Department of Transportation and Department of Housing and Urban Development can make major contributions to the study and to the implementation of research and demonstration projects in transportation.
>
> In fact the resources they can draw on are far greater than any resources that are available to the Administration on Aging.
>
> This should continue to be the case.
>
> I plan, therefore, to work directly with the Secretary of Transportation and the Secretary of Housing and Urban Development in order to carry forward a joint study, to develop joint research and demonstration projects, and to present a joint report on the issues identified in section 412.
>
> This process can be started by taking advantage of studies that have either been completed or that are in process by capturing, recording, and evaluating the Administration on Aging experiences under titles III and VII, as well as the

[14] Public Law 93–29, approved May 8, 1973. See ch. VII, p. 103, for discussion of other provisions.

[15] Section 412 of title IV, pt. B authorizes research and demonstration grants for experimenting with new methods, improving coordination, and developing innovative solutions for special problems.

[16] February 28, 1974, hearing cited in footnote 6.

Department of Transportation experiences under their existing authorities, and by utilizing other resources that are now and will be available to the three departments.

I will be in a position to report to this committee within the next 45 days on the plan for the study, the plan for demonstration projects, and what we expect to cover in the report which is to be submitted to the Congress by January 1, 1975.

Asked by Senator Chiles whether he had requested funds for the study, the Commissioner said he believes that he can work "from existing resources" on the first phase of the study, but that this situation may change after he reviews the findings of the interim report due 45 days from the date on which he testified.

The Commissioner also informed the committee that by March 15 the Cabinet-level Committee on Aging was to establish an Interdepartmental Task Force on Transportation.

C. Areas of Concern

High among the matters of concern to witnesses at the February hearing was the gasoline shortage and its impact upon programs serving older Americans.[17]

In addition, the testimony raised other issues to be examined in some detail at future hearings and in a report on transportation to be issued within the next year.

VITAL NEED FOR TRANSPORTATION

A point made often during the hearings was the special need for mobility among older Americans. William R. Hutton, Executive Director for the National Council of Senior Citizens, said that being without transportation is like having a modern kitchen with all the latest appliances and no electricity.

"Lack of transportation," he added, "is a barrier to obtaining necessities and necessary services, a barrier to socialization, a barrier to partaking in activities, a barrier to mental growth or even keeping one's sanity. Lack of transportation is a cause of stress and worry, a cause of loneliness, a cause of hunger, a cause of undue suffering, and, in fact, might be a cause of death."

Among the factors related to present transportation inadequacies among the elderly, according to Hutton and other witnesses, are:

—Deterioration of public transportation, generally, has intensified mobility problems of older Americans, particularly since only about 47 percent are licensed to drive.

—Old neighborhood structures are also deteriorating, and many corner neighborhood stores are being replaced by big shopping centers accessible only by automobiles.

—Important as transportation problems of the elderly in cities[18] (three-fourths of older Americans live in urban areas), rural needs are also acute.

[17] See ch. VI, p. 103, for additional details on problems caused by the energy crisis.

[18] See testimony by Dr. Francis Carp (Feb. 25, hearing cited in footnote 6, for additional testimony on urban elderly.

Margaret H. Jacks, Director of the Florida Division of Aging, described the situation in her State:

> Of the 67 counties in Florida, 15 are entirely rural with 11 additional counties with individual population of less than 15,000. There are only 5 counties where public transportation is universally available. In 40 counties there is no transportation except for an occasional small taxi service in some of the rural towns. In 22 counties there is limited transportation consisting of taxi service or a limited bus service which in several communities is a part of a demonstration project.[19]

THE "DEMAND-RESPONSIVE" CONCEPT

Much testimony dealt with ways in which to improve public transportation systems which serve the general public. Several witnesses, however, described the development of subsystems directly intended to meet the needs of the elderly and others called the "transportation disadvantaged." These subsystems are described as "demand-responsive," or "Dial-A-Ride" because the would-be passenger must make his own request for service.

In Rhode Island, for example, a nonprofit organization called Senior Citizens Transportation is providing 10,000 subsidized rides per month with 27 minibuses on a statewide basis. Radio dispatching is done through a station in the northern part of the State and another in the southern part. Ten vehicles were contributed by Community Action Program (Office of Economic Opportunity) agencies, and operating funding is provided largely through the U.S. Administration on Aging.

Eleanor F. Slater, Coordinator of the Rhode Island Division on Aging, gave this description of the importance of flexibility in providing transportation for the elderly:

> I would like to say that this is a door-to-door bus system. It is a system that serves the elderly, and goes where they need to be taken, and taken from their home and delivered back to their home. This is terribly important; I think that many of the public transportation systems have set up rules, and use it or not, that is the way we go, and this is our timing. I think we have demonstrated in Rhode Island that our system really takes the people when and where and back to their homes when they need the transportation most.[20]

In Missouri, which ranks sixth in the Nation in the percentage of 65 plus population, a not-for-profit corporation called the Older Adults Transportation Service, Inc. (OATS) now has 10,000 members and expects to have 25,000 late this year. The basic cost to the user is $6 the first year and $5 each subsequent year, as well as 4½ cents a mile for contribution. Fourteen-passenger yellow minibuses make the door-to-door stops; trips are made on a first-come, first-served basis. Volunteer OATS county committees organize routes and bus schedules, enlist the help of local organizations, and assist in hiring of the local

[19] February 25, 1974, hearing cited in footnote 6.
[20] February 25, 1974, hearing cited in footnote 6.

bus drivers. Federal funds have provided the bulk of support thus far, but the goal is a roughly 50/50 matching basis by the end of this year.

The importance of demand response concept was described at the hearing by Peter M. Schauer, OATS General Manager:

> OATS does not feel it should be compared with any of the major transit systems or any taxis because OATS considers itself a transportation value not available anywhere else at even twice the price. That is, OATS gives door-to-door transportation (not station to station) with trained, friendly drivers who have a real concern for the needs and desires of the OATS riders.[21]

Several other examples of flexible routing concepts were described at the hearings. The Suwannee Valley Transit Project [22] of northern Florida, has implemented several "Paul Revere" exceptions to routing schedules, to help people who live far away from bus stops. A representative [23] of a major transit system expressed sympathy toward the concept of providing "a specialized demand responsive service specifically designed to meet the needs and disabilities of the severely handicapped and aged infirm."

But, he added "A lack of a clear, affirmative program and policy on a Federal level has been a hinderance to development of such systems in the past."

WARNINGS ABOUT FRAGMENTATION

Important as pilot, experimental programs may be, they should not reduce momentum for more far-reaching solutions.

This warning was issued at the hearing by William G. Bell, Ph. D., associate professor and director, Program in Social Policy and the Aging, Department of Urban and Regional Planning, Florida State University.

Dr. Bell and William T. Olsen associate professor and director of the Transportation Center at Florida State University, have worked with Florida State agencies to conduct annual transportation conferences on transit programs for the transportation disadvantaged.[24] One of their major goals is the development of more coherent Federal-State policy for transportation deprived Americans.

Bell's testimony described recent transportation experiments addressed to the elderly. He said that reduced fare programs exist in more than 50 cities, but that this kind of program "does nothing for areas where no mass transit system is operative and further, it assumes the present routes, bus stops, and other system features are designed to fit requirements of the elderly." [25]

Demand-responsive systems, he said, add considerable flexibility and make it possible for some impaired elderly to obtain door-to-door transportation.

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[21] February 25, 1974, hearing cited in footnote 6.
[22] See testimony by John Lawson, project director, Feb. 25, 1974, at hearing cited in footnote 6.
[23] See testimony by Peter J. Andolina, superintendent of transit planning, Metropolitan Dade County Transit Authority, Dade County, Fla., Feb. 25, 1974, at hearing cited in footnote 6.
[24] The most recent proceedings are pts. I, II, and III, "New Directions in Planning and Action in Transit Programs for the Transportation Disadvantaged, Nov. 28, 29, 30, 1973, St. Petersburg Beach, Fla.
[25] February 27, 1974, hearings cited in footnote 6.

"Difficulties attendant to adding demand-response vehicles to mass transit," he added, "are primarily those of rationalizing the expense of extra vehicles, communication equipment and personnel required."

Bell listed a number of experimental "microsystems" adapted to special needs of particular groups; including transportation cooperatives operated by retirement communities, senior centers or private groups; subsidized use of taxis and jitneys, intermittent or regular use of school buses; use of Government surplus vehicles; and station wagons or small buses provided by health and social agencies transported selected clientele.

"Unfortunately," said Bell, "these special purpose systems rarely reflect a high degree of advanced planning; they tend to be short-term, usually high cost-per-unit of service, oversimplified solutions to complex problems which require comprehensive planning, coordination, and control. Special purpose systems may drain off pressure on local authorities responsible for public transit developments and thereby deter or divert the comprehensive, more lasting, and efficient solution. Moreover, knowledge derived from these experiments which could be profitably shared by transit planners is generally unavailable due to lack of thorough documentation, or test results may not be disseminated."

A related problem was traced by one witness [26] to federally authorized programs which include transportation components:

> The local social service agencies with transportation elements as part of their program receive direct or indirect funding from various Federal sources. HEW, HUD, and OEO have all been involved in the funding and/or planning of social service related transportation programs. They have all established different guidelines with differing eligibility and operating restrictions. In many instances the state agencies acting as the conduits of Federal funds have established overlapping guidelines and requirements. What's more, these Federal and State guidelines have been in a constant state of flux. For example, during 1973, the guidelines for transportation services under titles IV–A and XVI of the Social Security Act changed on almost a monthly basis. The individual local agencies like the Community Action Agency, the Division of Family Services, Model Cities, and the local Department of Housing and Urban Development were so confused and uncertain about their own transportation programs that the thought of unifying their programs with those of other agencies was not feasible. To add to this air of confusion and uncertainty, Federal administration funding cutbacks and the impoundment of funds put the longevity of many of these social service agencies and/or their transportation programs in question. This was and is hardly the atmosphere necessary to promote cooperative interaction between social service agencies.

Bell asked for action on new policy directions developed by him and Dr. Olsen.

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[26] Testimony by Mr. Andolina: Feb. 27, 1974, hearing cited in footnote 6.

They include: Recognition of urban mass transit "as a social services delivery system, rather than as a private enterprise system;" greater flexibility in Federal funding of operating costs, broadening of the constituency of transportation systems serving the elderly by integrating requirements of older persons with services demands for equally disadvantaged groups; "increased emphasis on human values and the social and economic goals of urban development; enforcement of the Federal law declaring that elderly and handicapped persons have the same right as other persons to utilize mass transportation facilities and services; and centralization of transportation planning for the elderly in State departments of recommendations."

FINDINGS AND RECOMMENDATIONS

Still in its early stages, the current Senate Committee on Aging survey of progress and problems in meeting transportation needs of older Americans cannot yet offer definitive findings and recommendations. The committee, however, can point out that:

- **Transportation difficulties of the elderly apparently are intensifying. Contributing factors are the decline in public transportation in many big and small communities throughout the Nation, the thrust outwards of suburban development and heavy reliance upon the automobile as the major means of travel, the energy crisis, and high fares for people on fixed incomes.**
- **Federal policy in regard to transportation for older Americans and other "transportation deprived" is far from clear, despite recent enactments authorizing action in this area.**
- **The administration should take immediate steps to include funding for the transportation survey and model projects mandated in section 412 of the Older Americans Comprehenhensive Services Amendments of 1973. Failing that, Congress should insist that such funds be appropriated and put to use at the earliest possible date.**
- **Administration action in submitting the Unified Transportation Act of 1974 is welcome because it can lead to orderly examination of Federal policy on the transportation disadvantaged, but only if the administration and the Congress recognize the clear need for far-reaching overall action needed to improve national public transportation resources at a particularly crucial period in their development.**

II. HEARING AIDS AND OLDER AMERICANS

Medicare provides much assistance to older Americans, but among the most conspicuous shortcomings in its coverage is provision for hearing aids and related services for older persons with hearing loss.

Often pointed out, this gap nevertheless persists. One reason is the expense of providing such coverage; another a sharp difference of opinion on how aids and services should be provided.

Testimony at a 1973 congressional hearing [27] provided a new examination of the need and the issues.

A. Magnitude of the Problem

A National Institute of Health report [28] estimates that more than 20 million people in the United States have communicative handicaps, and that the greatest incidence of hearing loss appears to be among persons 65 years of age or older.

Tom Coleman, executive director of the National Association of Hearing and Speech Agencies, adds: [29]

> A 1971 publication of the Bureau of Vital Statistics stated that 5,696,000 persons were hearing impaired in an over-65 population of 20,065,502. This is an incidence of more than 28 percent in this special age group of Americans.

Dr. Robert J. Ruben, Chairman of the department of otorhinolaryngology at Albert Einstein Medical Center in New York City, said that at least 13 percent of elderly Americans are afflicted with a *combination* of hearing losses.

To demonstrate the seriousness of such losses, Dr. Ruben described problems encountered by two of his patients: [30]

> The first is a gentleman, in his sixties, who owns a small truck. He earns his living by trucking fruits and vegetables from the wholesale market to a number of local merchants. He is totally deaf in one ear and has a severe hearing loss in the other ear. Unless something is done to improve the hearing in his one remaining ear, he can no longer drive his truck safely or hear the purchase orders given to him, and he will be forced to stop working.
>
> The other is a grandmother and in her seventies and in excellent health. She has suffered from a gradual hearing loss for the past 15 to 20 years. Now, she has become withdrawn from her children and grandchildren. She is afraid to go out shopping or walk in the streets because she cannot hear traffic. Her life has become totally isolated and lonely. Her lack of responsiveness has on many occasions been incorrectly interpreted by her family and friends as a lack of interest or senility. In reality, she does not hear, and she is afraid of her progressively silent world.
>
> These are just two of the hundreds of thousands of elderly Americans who are afflicted with hearing loss. Many, if not most of these individuals, may be helped to hear better and to improve their ability to communicate at a level which is socially and psychologically acceptable.

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[27] "Hearing Aids and the Older American," hearings by the Subcommittee on Consumer Interests of the Elderly, Senate Committee on Aging, Sept. 10–11, 1973, Washington, D.C.
[28] "Human Communications and Its Disorders," 1969.
[29] Page 325, hearings cited in footnote 27.
[30] Page 217, hearing cited in footnote 27.

B. Reasons for Action at this Time

Senator Frank Church, who conducted the hearing, opened the proceedings by saying that few disabilities have more harsh impact upon the elderly than severe hearing impairment. Medicare, he added, should be called upon to help; and he said he believes that action is more feasible at this time than it has been in the past.

> A few weeks ago, for example, former Health, Education, and Welfare Secretary Wilbur Cohen told this committee that in 1965 he had opposed Medicare coverage of hearing aids because he felt that Medicare could do only so much in its early years. But, he now feels that it would be feasible to do so. Furthermore, he believes that a very simple deductible, such as 20 percent of the cost of the hearing aid, could keep administrative difficulties to a minimum.[31]

Dr. Roy F. Sullivan, associate professor at the department of speech arts and speech pathology/audiology at Adelphia University, said that advances in design of hearing aids have considerably improved the usefulness of the devices within recent years. Using industry estimates, he said that approximately 3,750,000 65+ persons might be eligible for hearing aids if Medicare were to cover them.[32]

C. Issues and Problems

Sharp differences of opinion arose at the hearings on issues related to the ability of the hearing aid industry to deliver aids and services without imposition of new controls and procedures.

A panel of witnesses representing the Retired Professional Action Group—drawing from a 300-page report [33] prepared at the suggestion of Mr. Ralph Nader—said that 16 months of study had persuaded them that grave difficulties would arise if Medicare were to rely upon the industry, as now constituted:

> The public should not support a system in which the industry would profit further from tax dollars until: (1) Consumers first obtain medical clearance and/or clinical audiological testing prior to the purchase of an aid, (2) the public can be assured that dealers entering the program are fully qualified to serve the public, and (3) the marketing and pricing system is changed so that reasonable charges are made for hearing aids and services.[34]

RPAG also said that the average price of a hearing aid is $350 to $400, "an obvious economic barrier to lower-middle and low-income groups."

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[31] Page 2, hearing cited in footnote 27.
[32] Page 46, hearing cited in footnote 27.
[33] *Paying Through the Ear; A Report on Hearing Health Care Problems*, RPAG, 1973.
[34] Page 84, hearing cited in footnote 27, letter from Elma Griesel, RPAG executive director.

Industry spokesmen denounced the RPAG report and argued that the hearing aid industry organization was well-suited to provide service under Medicare.

James Ince, executive secretary of the Hearing Aid Industry Conference, said: [35]

> (1) Some 5,500 dealerships provide hearing aids and hearing aid services to every community in the country, contrasting sharply with other proposed systems utilizing principally metropolitan facilities.
>
> (2) Dealers provide same-day service—no waiting, no delays. That is seldom true in the other systems. Many clinics have delays of weeks and even months for the first appointment, as you elicited from one of the witnesses yesterday.
>
> (3) The present facilities are already in place, equipped, and almost perfectly distributed. No investment of Government funds has been made or is required. Contrast that, Mr. Chairman, to the millions upon millions of tax dollars the other systems would demand for capital items.
>
> (4) The dealer is in business to serve the hard of hearing, so he carries his message persuasive to his prospects. Hard-of-hearing people need persuasion and demonstration of how they can be helped. The dealer aggressively serves this need as a businessman, and that is the principal reason we are able to help more people every year. The opposite, of course, is that when the initiative for getting help is left to the hearing impaired, they do not get it—even if the aid is given away. In European government systems in which hearing aids are free, use on a population basis is often lower than in our present U.S. system where most hearing aids need to be paid for by the user.
>
> (5) We believe that utilizing the present delivery system will mean that Medicare can deliver hearing aids for under $300 each, and that is the total cost, without a nickel of the taxpayer's capital required for plant, equipment, or personnel. That contrasts to unknown or excessively high costs in other proposed systems.
>
> (6) Under the present system, Medicare hearing aid distribution would be placed in the responsible hands of the physician as the qualifying authority. The physician can determine whether an audiologist or any other involvement is necessary. Most can and should go straight from the physician to the hearing aid dealer. Some other proposed systems build in the tremendous and unnecessary expense and administrative delay of mandatory clinical audiological work in every case.

The Hearing Aid Industry Conference and the National Hearing Aid Society submitted plans for hearing aid procurement under Medicare.

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[35] Page 192, hearing cited in footnote 27.

Close scrutiny of plans to provide assistance to older Americans with hearing loss is essential for development of sound public policy on the matter of Medicare coverage. Issues are complex, but the development of such policy is mandatory because of the serious disability caused by hearing loss among older Americans. The subcommittee will continue its examination of issues and alternatives.

III. CONDOMINIUM CONVERSION: A NEED FOR CONTROLS

Condominiums [36] are the most popular items in the real estate business today, and in the absence of local government controls this new housing phenomenon has brought undue hardship to many elderly citizens.

Problems with condominiums have occurred both in new construction and in the conversion of large, old apartment buildings.

The new construction of condominium units has caused problems for many prospective owners, and both the Securities and Exchange Commission and the Federal Trade Commission are conducting studies of possible deceptive sales practices.[37]

A very different set of circumstances occurs when an old rental apartment building is converted to condominiums, and it is here that the unprepared older persons may be suffering the most.

The growing trend to condominium conversion is popular in large, old, stately apartment buildings which, more often than not, have a very high percentage of elderly tenants. The old buildings often need major repairs or additions (such as air conditioning or dishwashers) to bring them up to today's modern standards. With inflation and present-day construction costs so high, the cost of fixing up old buildings usually means that rents becomes so high the residents can't afford them. Converting the building to condominiums provides the owner with a quick source of capital, and ends his battle with rent controls, where they exist.

Unfortunately, this new trend also has its victims. Many tenants, especially older people, cannot afford to buy the unit they have been renting, especially if extensive renovation has raised the price beyond their reach. No matter how long they have lived there, they may be suddenly without a place to live. They must find, with little notice or help, a new apartment in an area that usually suffers from an acute moderate-income housing shortage.

Older persons often cannot come up with the down payment, and even if they can, many lenders hesitate to lend money for more than 20 years to persons over 60 years old.

Other problems confront the prospective condominium buyer who would like to stay in his apartment. In many cases, he does not have much time to make up his mind. Thirty-day notices to buy or vacate

[36] Condominium ownership is defined as "ownership by each of two or more persons of an estate in residential real property consisting of a separate interest in one or more dwelling units together with an undivided interest in such common areas or facilities as hallways, recreational areas, and open space."

[37] New York Times, January 27, 1974, p. 1.

are common. Tenants are also given little information about the structure they are being asked to purchase. Information on vital issues are often unavailable such as how long the owner plans to continue management, the life expectancy of the roof, the heating system, or the elevators, and prospective fees and costs.

The rapid trend toward condominums has occurred with virtually no control from local ordinances or State legislation. Many States, cities and counties have begun to respond to this obvious need.

Suggested regulations [38] include provisions which would require: (1) At least 90 days notice of impending conversion, (2) full disclosure of the condition of the building, (3) first options on purchase to the present tenant, (4) simplified sales contracts, and (5) the possibility for a prospective buyer to reconsider a contract agreement prior to sale. At least one State, New York, has a law requiring the approval of 35 percent of the tenants before conversion may occur.

The Special Committee on Aging is exploring the issues raised by the move toward condominiums, and is considering possible legislation to encourage condominium control in Washington, D.C.

As more and more apartment buildings convert to condominiums, fewer and fewer rental units will be available on the market. Even if stiff controls are established, no one has come up with a real solution to the problem of people who just want to live out their lives as renters rather than owners, and for many elderly, renting remains a decided preference.

IV. FRAUDS AGAINST THE ELDERLY

Deceptive or shoddy practices affecting the elderly have already received attention from the Senate Committee on Aging.[39] and Federal and State agencies, but the need for continuing concern is readily apparent. Reports submitted to this committee by the Federal Trade Commission and the U.S. Postal Service [40] indicate that both units have issued special publications meant to inform the elderly consumer about pitfalls in the market-place.

The Postal Service is particularly informative about specific matters of concern to its inspectors. About medical frauds, it says:

> Rapidly rising medical costs *and a lack of proper insurance coverage* (emphasis added), 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 1973 was over $3 million.

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[38] Some States, like New York, already have stiff condominium controls, but many States have virtually no regulations at all. Many local governments are legislating in this area especially if there is a high concentration of apartment buildings under their jurisdiction (for example: Baltimore City Council, and the county governments of Prince Georges and Montgomery Counties in the Washington metropolitan area.).

[39] See *Frauds and Deceptions Affecting the Elderly,* Jan. 31, 1965 and annual reports since then.

[40] See app. 1, item 13, p. 267, and item 21, p. 321, for full texts.

The report says that some schemes can be considered dangerous, as well as false and misleading:

> Such was the case when 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.

Postal investigations brought about the discontinuance of 103 questionable promotions in the medical fraud category in fiscal year 1973, according to the report, which also warns against:

—Fraudulent solicitation of funds.
—Work-at-home schemes which "involve an infinite variety of products and/or services to be manufactured, sold, or performed in the home."
—Home improvement promotional campaigns and the possibility "that *an upsurge in the questionable sale of furnaces, insulation, etc., will be seen due to the present energy crisis*" (emphasis added).
—Questionable business opportunities including distributorship, franchises, vending machines and other lures to investors. The report adds: "Retired and disabled persons lead the list of individuals who are preyed upon each year to 'put their savings to work and supplement their incomes.'"
—Land sales swindles, although "concerted attention" within recent years has reduced their numbers.
—Matrimonial schemes directed at lonely people, including the elderly.

The Postal Inspection Service is increasing its public education and fraud preventive programs.

A. Arthritis: A Special Concern

Arthritis in some form probably affects tens of millions of Americans, and it is of special concern to older persons (although it is by no means limited to them.) An estimated 10 percent of those receiving aid to the permanently and totally disabled is accounted for by arthritis; and arthritis in 1970 cost about $9.2 billion in medical care bills and lost wages.[41]

Frauds and rackets robbed arthritis victims of over $400 million in 1972, according to the Arthritis Foundation.[42] One reason for the success of such schemes, according to the foundation, is that arthritis has a way of coming and going unpredictably, even though relief may be only temporary.

The foundation adds:

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[41] From statement by Senator Alan Cranston, p. S. 23712. Congressional Record, Dec. 21, 1973.

[42] See, "Arthritis Quackery: A $403 Million Racket," published by the Arthritis Foundation, 1212 Avenue of the Americas, New York, N.Y. 10036.

Don't think, however, that because there is no cure there is also no effective treatment for arthritis. On the contrary, legitimate treatment by a qualified doctor can bring relief and prevent disability. One way to recognize a responsible physician is that he'll never claim he can cure arthritis, only that he can control it.

B. S. 2854: A Plan of Action

Actions by law enforcement agencies against outright fraud are essential, but more widespread protection can be assured only by public understanding of the disease and by intensified efforts to eliminate arthritis or further control it.

Senator Alan Cranston on December 21, 1973 offered a National Arthritis Act (S. 2854) intended "to advance a national attack on arthritis." The bill would broaden research efforts; encourage arthritis screening, detection, and control programs; and establish a task force to develop a national arthritis plan.

The Senator said: "The National Arthritis Act is directed at a disease problem that cuts viciously into the life of 20 million Americans. When enacted and fully implemented, this act can help improve the lives of pain and disability for these 20 million Americans."

CHAPTER XI

AGED PERSONS IN MINORITY GROUPS

All persons 65 or older are members of a large minority group in one very real sense; they constitute about 10 percent of our total population. As a group they share many common concerns: low income in retirement, soaring food prices, transportation difficulties, rising health costs, and now the energy crisis.

But for the elderly who are members of minority groups—such as blacks, Indians, Mexican-Americans, and others—these problems are frequently intensified. And all too often they are exposed to a form of "multiple jeopardy" because of age, race, nationality, language barriers, and false stereotypes.

I. POVERTY IN THE EXTREME

Inadequate income continues to be the foremost problem confronting most older Americans. And this is certainly true in the case of the 2 million elderly minority members. But their problem is usually much more extreme. One clearcut indication is that their poverty rate is approximately twice as great as for the elderly white population.

A. Poverty Among Minority Aged

In recent years major advances have been made in the area of economic security [1] for older Americans, in large part because of Social Security increases. From 1967 to 1972, about 1.5 million elderly whites were removed from the poverty rolls—at a time when the overall white aged population increased by more than 1.7 million.[2]

POVERTY BY RACE FOR NONINSTITUTIONALIZED PERSONS 65 AND ABOVE

[In thousands]

	1959	1967	1971	1972
Total 65-plus population	15,557	18,245	19,827	20,117
Living in poverty	5,481	5,388	4,273	3,738
Percent poor	35.2	29.5	21.6	18.7
Total Negro population 65-plus	1,138	1,341	1,584	1,603
Living in poverty	711	715	623	640
Percent poor	62.5	53.3	39.3	39.9
Total white population 65-plus	14,344	16,791	18,087	18,340
Living in poverty	4,744	4,646	3,605	3,072
Percent poor	33.1	27.7	19.9	16.8

Source: Bureau of the Census.

During this same period the overall economic position of elderly minority groups has also improved, but at a substantially more

[1] For a discussion of some of the major legislative advances in 1973 in the area of economic security, see pp. 157–162.

[2] Statistical information for this chapter has been obtained from the Bureau of the Census.

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modest level. Social Security increases—though welcome for the aged minority—have not had the same impact as for elderly whites. First a much higher proportion of aged blacks, Indians, Mexican-Americans, and others do not have sufficient coverage to qualify for Social Security benefits. Second, an across-the-board benefit increase ordinarily does not yield as large a benefit boost for members of minority groups because the raise is applied to a much lower base.

In 1972 (the latest date complete information is available) 3.1 million minority group members received Social Security benefits. All but 338,000 persons in the minority group classification were Negroes. As a group, Social Security benefits for minority persons were substantially lower than for the white population. Average monthly benefits for retired workers amounted to $165.10 for white persons in this classification—or 26 percent higher than the $130.76 figure for Negroes similarly situated. This same pattern was true for almost every category of benefit payment.

AVERAGE AMOUNT OF MONTHLY BENEFITS IN CURRENT-PAYMENT STATUS AT THE END OF 1972, BY TYPE OF BENEFICIARY AND RACE

Type of beneficiary	Total	White	Negro	Other
Retired workers and dependents:				
Retired workers	162.35	165.10	130.76	149.07
Men	179.44	182.41	146.29	157.04
Women	140.11	142.63	111.88	124.39
Wives and husbands	84.10	85.62	61.49	62.78
Children	59.90	65.12	43.82	42.45
Children under age 18	49.44	53.82	39.52	38.12
Disabled children aged 18 and over	75.91	77.82	56.56	63.51
Students aged 18 to 21	80.13	84.85	60.02	60.52
Disabled workers and dependents:				
Disabled workers	179.32	183.54	155.79	164.58
Men	190.84	195.08	167.67	170.64
Women	151.19	155.41	127.64	140.15
Wives and husbands	54.39	56.92	41.13	40.24
Children	49.38	52.82	36.96	34.87
Children under age 18	46.88	50.15	35.37	32.83
Disabled children aged 18 and over	69.08	71.50	54.44	52.89
Students aged 18 to 21	69.66	73.87	51.86	54.08
Survivors of deceased workers:				
Widows and widowers	138.18	139.93	113.07	118.77
Widowed mothers	115.45	122.72	88.60	88.75
Disabled widows and widowers	109.54	112.90	90.99	96.46
Parents	138.95	141.65	123.78	114.75
Children	110.36	117.89	82.14	83.01
Children under age 18	106.87	114.95	79.50	79.59
Disabled children aged 18 and over	115.25	117.50	95.38	100.10
Students aged 18 to 21	126.63	132.34	97.77	101.03
Special age-72 beneficiaries:				
Primary	57.75	57.75	57.64	57.73
Spouse	28.98	28.98	29.00	28.99

Source: Social Security Administration.

B. Impact of Social Security Increases

1973 census data revealed that poverty among elderly blacks declined from 715,000 in 1967 to 640,000 in 1972. During this time span, the aged black population increased by 300,000, from 1.3 million to 1.6 million. But almost 40 percent of all Negroes 65 and above still had in-

comes below the poverty line in 1972.[3] Moreover, this rate (39.9 percent) was well over twice the overall level (16.8 percent) among the white aged population.

Even more disturbing though, poverty—both in terms of aggregate numbers and relative percentage figures—actually increased for the black aged population during 1972. At a time when the number of impoverished elderly whites declined by more than one-half million, poverty among Negroes 65 or older actually increased by 17,000. And the percentage of the black aged population living in poverty grew from 39.3 percent in 1971 to 39.9 percent in 1972. In sharp contrast, the proportion of impoverished aged fell from 19.9 percent to 16.8 percent.

Much of the poverty for blacks is still concentrated among persons living alone or with nonrelatives. In 1972 approximately five out of every eight aged, unrelated blacks (63.4 percent) were considered poor. Undoubtedly one of the most disadvantaged groups in our society would be elderly Negro women. More than two out of every three (68.4 percent) lived in poverty in 1972.

POVERTY BY RACE, SEX, AND FAMILY STATUS FOR NONINSTITUTIONALIZED PERSONS 65 AND ABOVE IN 1972

[In thousands]

	Total	Poor	Percent
Females, unrelated, 65 or older:			
Black	345	236	68.4
White	4,383	1,678	38.3
Males, unrelated, 65 or older:			
Black	201	110	54.7
White	1,221	264	21.6
Families with head 65 or older:			
Black	604	184	30.5
White	6,902	678	9.8
Families with male head 65 or older:			
Black	396	109	27.5
White	5,953	568	9.5
Families with female head 65 or older:			
Black	208	75	36.1
White	949	110	11.6

Source: Bureau of the Census.

II. POVERTY SYNDROME

Limited income for the minority elderly also takes its tragic toll in many other ways. And it is reflected in the overall poverty syndrome: a shorter life expectancy, poor health, malnourishment, and an absence of vitally needed social services.

[3] Poverty thresholds:

	1971	1972
Single person 65-plus (weighted average)	$1,931	$1,994
Nonfarm	1,940	2,005
Farm	1,652	1,708
Couple with head 65-plus (weighted average)	2,424	2,505
Nonfarm	2,448	2,530
Farm	2,082	2,153

Source: Bureau of Census.

Because of this lifelong struggle with deprivation, the proportion of minority persons 65 and above is considerably smaller than for the white aged. About 10 percent of the elderly population is in the 65-plus age category. But this proportion falls off sharply for minority groups: 7 percent for blacks, 6.8 percent for Cubans, 5.7 percent for Indians, 3.2 percent for Mexican-Americans, and 2.0 percent for Puerto Ricans.

A major reason is that the life expectancy is lower for minority groups than for the white population. For the white population it is 71.9 years at birth: 68.3 years for males and 75.6 years for females. In the case of other groups, it is 65.2 years at birth: 61.2 for men and 69.3 for women.

However, among the very advanced age groups, 75 and over, this trend is reversed. In the case of persons 85 and above, for example, life expectancy is almost twice as long for minorities as for the white population: 9.2 years compared with 5.1 years. Moreover, among the nearly 7,000 centenarians who received Social Security benefits in June 1973, about 12.5 percent were Negroes and members of other minority groups. Elderly blacks constituted 11.5 percent of the total, although they accounted for only about 8 percent of the entire 65-plus population. Some leading authorities [4] have suggested that this phenomenon may represent "survival of the fittest." They have theorized that minority members who were able to survive earlier hardships and live to an advanced age are especially hardy and durable.

LIFE EXPECTANCY, 1971

	Birth	45	65	75	85
Total population	71.0	30.3	15.1	9.5	5.3
Male	67.4	27.4	13.2	8.4	5.2
Female	74.8	33.2	16.9	10.4	5.4
White population	71.9	30.6	15.2	9.4	5.1
Male	68.3	27.7	13.2	8.3	4.9
Female	75.6	33.6	17.0	10.2	5.2
Other	65.2	27.3	14.6	11.7	9.2
Male	61.2	24.6	12.9	10.6	9.5
Female	69.3	30.0	16.1	12.6	9.0

Source: Vital Statistics Branch, Public Health Service, Department of Health, Education, Welfare.

Another indicator of the high degree of deprivation among elderly minority groups is their very low level of educational attainment. About one out of every eight persons 65 and above has completed less than 5 years of schooling. However, this ratio is more than six times as high among aged Mexican-Americans. Almost 75 percent have less than 5 years of education. And less than 1 percent have graduated from high school.

[4] See Dr. Inabel B. Lindsay, Dean Emeritus, Howard University, *The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States,* Special Committee on Aging, U.S. Senate, 1971, 92d Cong., 1st Sess., p. 22.

PERCENT OF THE POPULATION 25 YEARS OLD AND OVER WHO HAD COMPLETED LESS THAN 5 YEARS OF SCHOOL OR 4 YEARS OF HIGH SCHOOL OR MORE, BY ETHNIC ORIGIN, MARCH 1972

Years of school completed and age	Total population	Spanish origin		
		Total[1]	Mexican	Puerto Rican
Completed less than 5 yrs of school:				
Total, 25 yrs old and over	4.6	19.3	26.7	20.2
25 to 29 yrs old	.8	5.5	7.3	5.8
30 to 34 yrs old	1.4	8.4	12.6	8.7
35 to 44 yrs old	2.5	15.9	21.0	19.9
45 to 54 yrs old	3.4	25.1	33.1	39.9
55 to 64 yrs old	5.6	30.8	47.9	(2)
65 yrs old and over	12.2	51.3	74.8	(2)
Completed 4 yrs of high school or more:				
Total, 25 yrs old and over	58.2	33.0	25.8	23.7
25 to 29 yrs old	79.8	47.6	42.9	30.9
30 to 34 yrs old	73.9	42.7	40.1	22.6
35 to 44 yrs old	66.8	35.2	28.0	27.2
45 to 54 yrs old	59.8	24.9	14.2	21.3
55 to 64 yrs old	46.7	20.6	8.8	(2)
65 yrs old and over	32.0	12.1	.6	(2)

[1] Includes other persons of Spanish origin, not shown separately.
[2] Base less than 75,000.

Source: "Current Population Reports: Population Characteristics", U.S. Department of Commerce, Social and Economic Statistics Administration, Bureau of the Census, Series P-20, No. 238, July 1972, p. 5.

III. THE NUTRITION PROGRAM AND THE MINORITY ELDERLY

Following a struggle spanning nearly 2 years, the Nutrition Program for the Elderly Act was finally signed into law [5] in March 1972. Of special significance for elderly minority groups was language in the Senate Labor and Public Welfare Committee report that priority attention be given to the needs of low-income individuals.

The Senate committee report stated:

> **In making grants or awarding contracts, States must give preference to projects serving primarily low-income individuals and the State plan must assure that, to the extent feasible, grants will be awarded to projects operated by and serving the needs of minority, Indian, and limited English-speaking eligible individuals in proportion to their numbers in the State.[6]**

To a large degree, this was in recognition that hunger and malnutrition are much more prevalent among minority groups. Further insight into this problem was provided by Mrs. Louise Martin at a hearing conducted in Coeur d'Alene, Idaho in August 1973 on the health problems of the elderly:

> People living alone feel it doesn't make much sense to cook a meal for just one person. In some cases the person does not

[5] Public Law 92-258, approved March 22, 1972.
[6] S. Rept. 92-515 to accompany S. 1163, "Nutrition Program for the Elderly Act under the Older Americans Act of 1965, as amended", Senate Committee on Labor and Public Welfare, Nov. 29, 1971, p. 2.

know how to prepare certain foods. There is frequently a lack of personal funds to purchase adequate food. There is frequently a lack of transportation to obtain food. There are inadequate home visits by health workers to check on how older people are doing. Traditional high quality foods such as roots, berries, fish, and venison are not available for a number of reasons.

. . . Older people who have lived for a long time on low incomes have learned to like and eat only inexpensive foods high in carbohydrates.[7]

As of the week ending February 1, 1974, minority groups accounted for 37 percent of the 80,979 meals served under the nutrition program. For that particular week, 30,285 meals were served to the minority aged: including 1,463 to American Indians; 14,267 to Negroes; 1,068 to Orientals; 6,864 to Spanish speaking; and 1,623 to other minority groups.

The new Title III State and Community Programs on Aging also places emphasis on serving the minority aged. Section 903 (d)(1) of the regulations, for example, provides that in developing area plans special attention be given "to the needs of low income and minority older persons, and older physically and mentally disabled".

IV. NATIONAL CENTER ON BLACK AGED

One of the most positive developments in 1973 for elderly blacks was the establishment of a National Center on Black Aged. The Center, which was funded at $251,000 in July 1973 under a title IV research grant from the Administration on Aging, will be under the direction of the National Caucus on the Black Aged. The National Caucus was first established in the fall of 1970 to have some impact at the 1971 White House Conference on Aging in terms of policy issues affecting elderly Blacks.

The new center will fulfill several functions, including collecting data, engaging in research activities, disseminating information, encouraging the development of service programs, and working with other organizations in the field of aging. Hobart C. Jackson is the executive director for the National Center on Black Aged.

At the open house held at the center offices on January 4, Mr. Jackson discussed the impact of the SSI program for elderly blacks. He gave this assessment:

One hope on the horizon, at least, conceptually is the Supplemental Security Income Program—even though the benefit provided is disgracefully small. The program seems to be conceptually sound and we urge all of you present here this evening to work with us to see that the black elderly who are entitled to this meager income benefit actually receive it. So often minorities do not receive their entitlements under these

[7] "Barriers to Health Care for Older Americans", hearings before the Subcommittee on Health of the Elderly of the Senate Committee on Aging, part 7, Coeur d'Alene, Idaho, Aug. 4, 1973, pp. 640–1.

programs for various reasons which we shall not enumerate at this time. We should certainly join with others in getting amendments to this legislation so that the guaranteed annual income of every elderly person finally passes the poverty threshold or level.[8]

V. CALIFORNIA STATE ACTION

The California Joint Committee on Aging provided further insight into the problems and challenges of aged minority groups when it conducted two hearings (November 13 in Los Angeles and December 4 in San Francisco) on "Problems Confronting Elderly Ethnic Groups in California." In discussing the reasons for calling the hearings, Assemblyman Leo T. McCarthy, Chairman of the California Legislature's Joint Committee on Aging, said:

> Ever-increasing numbers of elderly black, brown, Filipino, Indian, Chinese, Japanese and other Asian residents are confronted with a multitude of specific problems related to their economic, social and physical well-being.[9]

In one form or another, the joint committee touched upon virtually all major issues affecting the ethnic elderly, including income, transportation, housing, health, nutrition, communications, supportive services, employment, public safety, legal services, and research.

Senator John V. Tunney, of the U.S. Senate Committee on Aging, also presented testimony at the joint committee hearing. He called for comprehensive action by Federal and State authorities to assure that income and service programs reach those who are meant to be served:

> In the case of the minority aged, all too often gaps exist between the "availability" and "accessibility" of programs and services meant to serve them. Without adequate outreach efforts, even the best conceived programs will be of little benefit for senior citizens.
>
> Closely related to this recommendation is the need for improved and expanded bilingual assistance, especially for Asian-Americans and Mexican-Americans. Like other minority groups they suffer multiple forms of jeopardy that come with being old, poor, and a member of a small minority within a minority. But they also have an added burden: a language barrier which aggravate their deprivation.
>
> At the Federal level, bilingual aides—even though their utilization has been far too limited—have proved to be enormously successful in assuring that persons with limited English-speaking ability qualify for programs meant to serve them. We don't need any more proof that these efforts work. What is needed is a genuine commitment to build upon these earlier successful achievements.

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[8] "NCBA NEWS", National Caucus of the Black Aged, National Center on Black Aged, Vol. 2, No. 1, Jan. 1974, p. 2.

[9] Press Release, California Legislature, Joint Committee on Aging, November 1, 1973.

> Finally, I think that it is crucial to consider the special problems of the ethnic elderly when programs are being developed for all older Americans. In the recently enacted Nutrition Program for the Elderly Act, the Congress included a provision to assure that special attention be given to the needs of minority groups. For example, special menus might be provided, where feasible and appropriate, to meet the particular dietary requirements arising because of religious reasons or ethnic backgrounds. This type of language, which became a part of the national hot meals program for older Americans, could also be incorporated in other Federal and State legislation for the elderly.[10]

Mr. Alverto Corruth, Indian Counselor, emphasized that the basic problem confronting elderly Indians who leave the reservation is difficulty in communicating with members of an urbanized society. He called for information and referral offices to provide coordination linkages with all public and private agencies concerning Indian problems. He also stressed that the office should be staffed by Indians.

Mrs. Willie Kimbrough, President of the Compton Committee on Aging, pointed out that a majority of elderly blacks live in substandard homes. She also said:

> Seniors lose their homes at an alarming rate as a result of not being able to pay high taxes; further, those who have income are discouraged from improving their homes for fear of increasing their taxes.[11]

Ms. Amalia Guerrero, of the Department of Mental Health, focused on the housing problems of Mexican-Americans.

In her judgment, the renter is in worse condition than the homeowner:

> The senior citizen that rents is worse off than the homeowner. They are the ones that live in the most neglected and dilapidated housing. Many are rat and cockroach infested, have stopped up plumbing and have faulty heating. Some housing is so old that windows are frozen and they cannot be opened. Senior citizens are often afraid to complain because usually the absentee landlord will threaten to raise the rent or evict them. Urban renewal programs often condemn homes and force senior citizens to sell at their price. The money offered is never enough to buy other property, and at this stage of their lives, senior citizens cannot afford to go into further debt even at low interest loans.[12]

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[10] Testimony by U.S. Senator John V. Tunney, "Problems Confronting Elderly Ethnic Groups in California," hearings before the Joint Committee on Aging, California Legislature, Los Angeles, California, November 13, 1973.

[11] Testimony by Mrs. Willie Kimbrough at hearing cited in footnote 10.

[12] Testimony by Ms. Amalia Guerrero at hearing cited in footnote 10.

VI. MINORITY TRAINING NEEDS IN GERONTOLOGY

One of the critical problems in the field of aging today is a dearth of trained personnel to deliver essential services for the elderly. Among the minority aged, this situation is intensified.

Witnesses at the Committee on Aging's hearings on "Training Needs in Gerontology" [13] made this point very emphatically.

Mr. Clavin Fields, Director of Gerontology at Federal City College, disclosed that no black college had received training funds in the field of aging from the Federal Government prior to 1971. He also pointed out that at universities receiving Federal funds to train gerontologists, less than 1 percent of the persons trained was black.[14]

Mr. Percil Stanford, Director of the Center on Aging at California State University at San Diego, expressed fear that the Administration's efforts to phase out funding for the Title IV Training program would eliminate or sharply curtail new programs to serve the minority elderly. He added:

> To discontinue provisions for long-term training in aging will only exacerbate a situation which already exists. That is, there are too few persons trained to work with older people in general, and there is an even greater need for trained persons to serve a variety of ethnic and other minority older people. If persons are going to be trained in any way to work with older people, they should have the appropriate knowledge to be effective with whatever culturally different persons they are serving.[15]

Mr. Stanford also challenged the Administration's emphasis on student loans, particularly as it relates to minority students:

> I would like to emphasize this particular outlet is not a good suggestion for most minority students, primarily because many of the students have not had a history of dealing with loan agencies and, further, they have not had a credit history in their families in many cases.
>
> In the San Diego area many of the banks are screening people very closely and are looking at their potential for success for payback, so this particular avenue is completely out in many, many cases.[16]

Finally, he spoke of the Institute of Minority Aged, which was held June 6–8, 1973 at San Diego under a special AoA grant. Mr. Stanford indicated that several important points were learned or confirmed by the Institute's activities, including:

- Each minority group faced similar basic problems, but the solutions for those problems could not be approached in the same way.

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[13] "Training Needs in Gerontology," hearings before the Senate Special Committee on Aging, Washington, D.C., June 19 and 21, 1973.
[14] See testimony by Mr. Clavin Fields at June 19 hearing cited in footnote 13, pp. 38–39.
[15] Pages 31–32 of June 19 hearing cited in footnote 13.
[16] Page 34 of June 19 hearing cited in footnote 13.

- Many approaches to the problems of minority groups fail to consider their major cultural variations.
- Very few minority persons are trained to deal with problems of the minority aged.
- The bulk of minority persons who work with the minority elderly do not have formal training at any level to deal with government bureaucracies.

VII. AN INFORMATION GAP

One of the major impediments for the development of a comprehensive national policy for all older Americans is a critical gap in essential data. What information is available is frequently outdated, misleading, and sometimes inaccurate. And all too often no intelligible data can be found.

Without more precise and complete information policy makers will continue to have difficulty in developing sound and sensible solutions for the special problems of minority groups.

But even with fragmented and limited data available, it is readily apparent that their needs are pressing and require immediate attention.

FINDINGS AND RECOMMENDATIONS

Recent legislative victories in 1973 can help to improve the economic well-being of elderly minority groups, including:

- **A two-step, 11 percent increase in Social Security benefits.**
- **Liberalization of the retirement test to permit workers under age 72 to earn up to $2,400 in 1974 before $1 in benefits will be withheld for each $2 of earnings above this exempt amount.**
- **A two-stage increase in the monthly income standards for the new Supplemental Security Income program, from $130 to $149 for qualifying aged individuals and from $195 to $219 for elderly couples.[17]**
- **Restoration of food stamp eligibility for SSI recipients.[18]**

But by whatever barometer one would now choose to use, the minority aged—whether they be Indians, Asian-Americans, Spanish-speaking, or blacks—have a less satisfying quality of life than the total elderly population. They run a substantially greater risk of living in poverty. And they are much more likely to experience other forms of anxiety and deprivation.

For far too long their deep-rooted problems have received scant attention.

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[17] For a more detailed discussion of this legislation, see pp. 157–159.
[18] See Chapter 1, p. 22, for additional details.

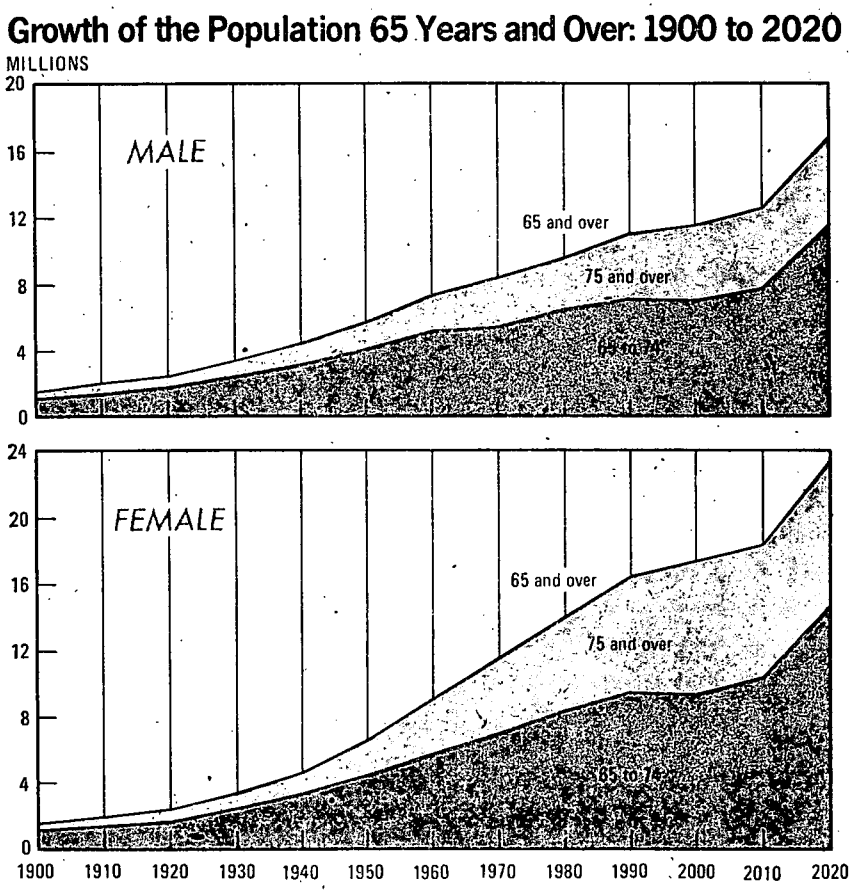
To deal more effectively with their unique and growing concerns, the committee:

- Plans to focus special attention on their special needs, as a part of the committee's study into "Future Directions in Social Security."
- Recommends that the income standards under the SSI program be raised to a level, which can at long last, eliminate poverty for all older Americans.
- Urges that outreach efforts be improved to seek out and find isolated and needy elderly members of minority groups who are eligible for SSI payments.
- Recommends that the Administration on Aging call together appropriate officials from Government agencies and members of minority groups for the purpose of improving and disseminating statistical information about the minority aged.
- Will give special consideration to developing legislation to reduce the Social Security payroll tax for low-income workers.

CHAPTER XII

AGING AROUND THE WORLD

Current dimensions and future projections of the 65+ population in the United States are familiar: today's upper age group of about 21 million will reach 29 million by the turn of the century, and about 40 million by 2020.[1]



[1] For additional statistical data, see "Every Tenth American," in the introductory material to this report. See also: Some Demographic Aspects of Aging in the United States, Current Population Reports, Bureau of the Census, February 1973.

Implications of a growing "retirement revolution" in the United States have won increasing attention,[2] but there appears to be ample reason for gerontologists in this and other nations to consider worldwide trends, as well.

I. THE UNITED NATIONS SURVEY

A report [3] issued in 1973 by the United Nations gave an impressive summary of the statistics of aging on a global basis, now and in the future.

In addition, it questioned whether nations, industrialized or still developing, have dealt wisely with serious economic and social problems related to aging.

The report said:

> . . . . in most countries, the phenomenon of aging among human populations is having profound effects on the structure and function of the family, on the work force and economic policies, on the goals and organization of health, education, and social services, and on the policies and practices of governments. With modern technology and primarily because of advances in medicine, more and more persons are living into the later stages of the life span. This trend is expected to accelerate.

As indicated in Table 1, the rate of increase of the 65 and over age group will be greater than that of the world's total population, as well as that of any other age group.

Tables 2 and 3 provide details on the growth that can be expected by the turn of the century. The UN report (cited in footnote 3) points out:

> It is significant to note that for the more developed regions the increase in the population as a whole will be 33 per cent, from 1970, while the 60 and over population will increase by 50 percent.
>
> For the less developed regions, the proportionate increase of the older population is even more pronounced; *while a 98 per cent increase is anticipated for the total population over the same time period, the increase for the 60 and over population will be approximately 150 per cent.*[4]

Among the issues raised by increased longevity throughout the world, according to the UN report, are:

—Fundamental changes in the structures of the family.
—Changing health needs and conditions of older persons.
—The need for specialized housing and living arrangements.

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[2] See ch. XIV, *Developments in Aging: 1971* (S. Rept. 92–784) May 5, 1972; and ch. XII, *Developments in Aging: 1970*, S. Rept. No. 92–46, Mar. 23, 1971; both documents are annual reports of the U.S. Senate Special Committee on Aging.

[3] *Question of the Elderly and the Aged: Conditions, Needs and Services, and Suggested Guidelines for National Policies and International Action, Report of the Secretary General*, United Nations, Aug. 28, 1973.

[4] Page 5, report cited in footnote 3.

—Programs for economic security which recognize the trend toward earlier retirement (see Table 4 for listing of retirement ages in industrialized nations).
—New thinking about the place of the elderly in the social structure.

The U.N. study, and the fact that the United Nations appears to be disposed to give continuing attention to aging around the world, are encouraging developments. The United States delegation to the U.N. should join in any efforts which will lead to more organized and extensive fact-gathering and action to deal with problems arising with greater and greater frequency as the world population continues to "age."

II. PROPOSED: A WORLD ASSEMBLY ON AGING

Senator Frank Church, Chairman of the Senate Special Committee on Aging, has proposed that a World Assembly on Aging be conducted within the next few years, possibly under the auspices of the United Nations.

In a speech prepared for the International Symposium on Housing and Environmental Design for Older Adults in Washington, D.C., on December 14, 1973, the Senator described the specific role he would like to see a World Assembly play:

> Everyone here, I believe, knows that in late 1971 the United States conducted a White House Conference on Aging. The purpose was to develop a national policy on aging. The expectation was that recommendations made at that conference would be implemented, at least partially, within the next decade. Many observers from abroad, some of them at this symposium, came to Washington for that conference. Some international dialogue occurred, but in my opinion, not enough.
>
> And so, almost a year late, I proposed that a world assembly be called.
>
> I did *not* think that it should be a gathering of scientists who would exchange research findings. That function is admirably fulfilled by the triennial International Congresses of Gerontology sponsored by the International Association for Gerontology.
>
> I did *not* think, either, that a World Assembly should be a group of experts exploring concepts or individuals topics. These functions are fulfilled by conferences, such as this one, and by stimulating courses sponsored each year by the International Center for Social Gerontology.
>
> I felt that what *is* needed is a convocation of national representatives to talk about national objectives on aging.
>
> In other words, a World Assembly on Aging would be a call for governments to meet, either regionally or centrally or both, for a global view of how governments can deal with

social and economic problems and trends resulting from what has been called a "retirement revolution."

Church said the Assembly could result in national commitments for action on aging. He also described "more modest, but achievable, potential accomplishments":

—A compilation, on a scale never before achieved, of information related to aging in advanced and developing nations.
—More accurate projections of impact of income maintenance and social service programs upon national economies at varying levels of development.
—Effects of increasing lifespan and other changes in population composition.

The Senator added:

> Such results were achieved in preparatory work which led to the United Nations Conference on the Human Environment in Stockholm in June 1972. A vast body of information, never before assembled, although for the most part it was available, was gathered and sorted through *in advance* of the actual conference. This alone would have been a major accomplishment, but of course much more has since occurred. The Stockholm conferees adopted more than 100 recommendations for international action, and a U.N. Environmental Agency was established.

Church emphasized that the World Assembly would not conflict with the purposes of the 10th International Congress of Gerontology scheduled to be conducted in Israel in June 1975. He said that planners of the International Congress are, in fact, supporting the World Assembly. He also said that gerontologists and others concerned about aging have given him encouraging commentary. Of 52 replies to letters sent by the Senator to 20 nations, all but five were in complete agreement on the need for a conference. The Senator also said that he is urging groups of concerned individuals in each nation to organize themselves into working committees to discuss the most appropriate ways of increasing interest in a World Assembly before formal efforts are made to secure UN approval.

Church added:

> We live on a planet where, the United Nations reports, the population will grow markedly more aged within the very next few decades. For everyone's sake, we must communicate. For everyone's sake, we must then act.

A World Assembly on Aging, well-planned and coordinated with other international forums on aging, would be a welcome and important timely step towards understanding and action on matters of concern to present and future older people in all nations. The United States delegation to the United Nations, at an appropriate time, should take the lead in advancing such an assembly.

TABLE 1.—EXPECTED CHANGES IN THE MAIN FUNCTIONAL GROUPS (IN MILLIONS), 1970–80

[Medium variant]

	World	More developed regions	Less developed regions
Total population:			
1970	3,632	1,090	2,542
1980	4,457	1,210	3,247
Increase	825	120	705
Percentage increase	22.7	11.0	27.8
Pre-school group (0 to 4 years):			
1970	508	96	412
1980	612	113	500
Increase	104	17	88
Percentage increase	20.5	17.0	21.3
School-age group (5 to 14 years):			
1970	836	196	640
1980	1,021	199	822
Increase	185	3	182
Percentage increase	22.2	1.5	28.5
Working age group (15 to 64 years):			
1970	2,098	693	1,405
1980	2,577	768	1,809
Increase	479	75	404
Percentage increase	22.8	10.9	28.7
Old age group (65 years and over):			
1970	189	105	84
1980	246	130	117
Increase	57	25	33
Percentage increase	30.2	23.7	38.2

Source: "World population prospects 1965–85 as assessed in 1968" (Population Division, Department of Economic and Social Affairs, United Nations Secretariat, Working Paper No. 30, December 1969), p. 18, table 9.

TABLE 2.—1970 POPULATION ESTIMATES AND PROJECTIONS FOR 1985 AND 2000, BY MAJOR REGIONS, WITH THE NUMBER OF THOSE 60 AND OVER

Region	Year	Total population (thousands)	Population 60 years and over: Number (thousands)	Population 60 years and over: Percentage of total population
World total	1970	3,631,797	290,697	8.0
	1985	4,933,463	406,750	8.2
	2000	6,493,642	584,605	9.0
More developed regions	1970	1,090,297	153,741	14.1
	1985	1,274,995	188,602	14.8
	2000	1,453,528	231,105	15.9
Less developed regions	1970	2,541,501	137,024	5.4
	1985	3,658,468	218,474	6.0
	2000	5,040,114	353,917	7.0

Source: Demographic material used in the U.N. report are based upon information obtained from the Population Division, Department of Economic and Social Affairs of the U.N. Secretariat.

TABLE 3.—1950–70 ESTIMATES OF PERCENTAGE INCREASE IN THE POPULATION AND PROJECTIONS FOR 1970–2000

Region and year span	Percentage increase of—: Total population	60 plus population	70 plus population
World total:			
1950–70	46.1	54.7	56.0
1970–2000	78.8	101.1	118.7
More developed regions:			
1950–70	27.1	59.3	65.5
1970–2000	33.3	50.3	70.0
Less developed regions:			
1950–70	56.1	49.9	44.6
1970–2000	98.3	158.3	186.9

Source: Demographic material used in the U.N. report are based upon information obtained from the Population Division, Department of Economic and Social Affairs of the U.N. Secretariat.

TABLE 4.—NORMAL RETIREMENT AGE FOR WOMEN AND MEN FOR 29 SELECTED COUNTRIES [1]

Country	Normal retirement age— Women	Men
1. Norway	70	70
2. Ireland	70	70
3. Denmark	67	67
4. Sweden	67	67
5. Iceland	67	67
6. Canada	65	65
7. Luxembourg	65	65
8. United States	[1] 65	[1] 65
9. Spain	65	65
10. Portugal	65	65
11. Netherlands	[1] 65	[1] 65
12. France	[1] 65	[1] 65
13. Finland	65	65
14. Switzerland	63	65
15. Israel	60	65
16. United Kingdom	60	65
17. Germand Democratic Republic	60	65
18. Germany, Federal Republic of	60	65
19. Austria	60	65
20. Poland	60	[1] 65
21. Australia	60	[1] 65
22. Belgium	60	65
23. Greece	57	62
24. U.S.S.R	[1] 55	[1] 60
25. Czechoslovakia	55	60
26. Japan	55	60
27. Italy	55	60
28. Hungary	55	[1] 60
29. Yugoslavia	55	60

[1] Normal retirement is defined as the stated age of retirement according to public policy. However, there is wide variation in the actual age of retirement; type of occupation (those doing heavy work usually retire younger), harshness of weather or working conditions and years of service are included among a wide range of exceptions. In the United States although 65 is defined as the age for full social security benefits, the majority of workers are now electing to retire at age 62 with reduced benefits. In the Netherlands, the age of 60 may be the time of retirement for those engaged in heavy work, while for others retirement may begin at 70. In France those working in the public sector may retire between ages 55 and 60. In Poland miners and teachers may retire at age 60. In Australia, if a man is unemployed for more than 1 year he may retire at age 60. In all the socialist countries of Eastern Europe, a number of exceptions or special situations may reduce the age of retirement; for example, in Hungary men engaged in heavy work may retire at age 55.

PART TWO

SUMMARY OF LEGISLATIVE ACTIONS TAKEN FROM JANUARY 1973 TO MARCH 22, 1974

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 SOCIAL SECURITY AND THE SUPPLEMENTAL SECURITY INCOME PROGRAM

5.9 Percent Social Security Increase (H.R. 7445)

A. Legislative History

H.R. 7445 (Extension of the Renegotiation Act) passed the House on May 9. On June 30 the Senate unanimously approved (74 to 0) H.R. 7445 with an amendment for a cost-of-living increase in Social Security benefits and other provisions. A conference committee was held on June 30 to resolve the differences in the House and Senate versions. The Senate agreed to the conference report on June 30. And, the House also approved the conference report (which included a cost-of-living increase in Social Security benefits) by a vote of 327 to 9.

B. Major Provisions

Benefit increase.—Public Law 92–336 authorized cost-of-living adjustments in Social Security benefits beginning in January 1975. H.R. 7445 provided for a special cost-of-living increase applicable to benefits for June 1974 to December 1974 to reflect the rise in the cost-of-living between June 1972 and June 1973 (5.9 percent).

Increase in earnings limitation.—The Act also increased the maximum annual earnings limitation for persons under 72 from $2,100 ($175 per month) to $2,400 ($200 per month).

Increase in taxable wages.—The maximum taxable wage base was increased from $12,000 to $12,600 in 1974.

Increase in Supplementary Security Income guarantee level.—The Federal guarantee under the SSI program was increased (effective July 1974) from $130 to $140 a month for aged, blind, and disabled persons and from $195 to $210 for couples.

Requiring State supplementation.—In many States, payment levels for the aged, blind, and disabled exceeded the Federal guarantee levels under the new SSI program. To assure that these individuals will not receive a reduction in their payments, the Act requires States to assure that no recipient on the rolls in December 1973 would have his pay-

ment reduced when the SSI program became effective in January 1974. States not providing this required supplementation of SSI benefits will not be entitled to Federal Medicaid matching funds.

Benefits for "essential persons".—H.R. 7445 extended SSI eligibility to individuals considered essential persons (generally a spouse under age 65 of an Old Age Assistance recipient over 65) under State adult welfare assistance programs—aid for the aged, blind, and disabled.

C. Status as of March 22, 1974

H.R. 7445 was signed into law (Public Law 93-66) on July 9, 1973.

11 Percent Social Security Increase (H.R. 11333)

A. Legislative History

H.R. 11333 passed the House on November 15 by a vote of 391 to 20. On November 30, the Senate approved (66 to 8) H.R. 3153, which also included a two-step, 11 percent Social Security increase and several other amendments. A House-Senate conference committee was conducted in December. The conference committee agreed to some provisions in H.R. 3153 and included them in H.R. 11333. Action by the conference committee on the remaining provisions in H.R. 3153 is tentatively set for 1974.

On December 21 the Senate passed H.R. 11333 by a vote of 66 to 0. The House also passed (301 to 13) H.R. 11333 on December 21.

B. Major Provisions

Increase in Social Security benefits.—H.R. 11333 provides an 11 percent across-the-board increase in Social Security benefits effective June 1974, with 7 percent of this amount payable for March 1974. This measure is designed as a substitute for Public Law 93-66.

Increase in the special minimum benefit.—Under prior law, the special minimum monthly benefit was computed by multiplying $8.50 by the number of years of covered employment after 10 but not greater than 30 years. H.R. 11333 increased this multiple from $8.50 to $9.00. Thus, the highest special minimum is increased in 1974 from $170 to $180 a month for workers with 30 or more years of coverage.

Cost-of-living adjustment improvements.—The automatic escalator provision will be improved by measuring the increase on the basis of the change in the consumer price index from the first quarter of one year to the first quarter of the following year (rather than from the second quarter in one year to the second quarter in the following year.) An exception will be made for the first automatic increase (effective for June 1975), which will be based upon the rise in the CPI between the second quarter in 1974 and the first quarter in 1975. Additionally, the effective date for the cost-of-living adjustment will be in June, instead of January. These two changes will reduce from seven months to three months the lag between the end of the calendar quarter used to measure the rise in the cost-of-living and the payment of the resulting Social Security increase. Moreover, the automatic benefit raise will be payable the month that the Supplemental Medical Insurance premiums will be revised, thus providing the opportunity to make both adjustments in benefit checks in the same month.

Supplemental Security Income standards.—Monthly income standards for the new Supplemental Security Income program will be

raised from $130 to $140 for eligible individuals and from $195 to $210 for qualifying couples. A further increase will be provided in July 1974: to $146 for single persons and $219 for couples.

Food stamp eligibility for recipients.—From January 1974 to June 1974, the eligibility of SSI recipients for participation in the food stamp and surplus commodities programs will be determined as though Public Law 92–603 and Public Law 93–86 had not been enacted—that is, on the basis of the income and assets requirements of the programs. (Public Law 92–603 had prohibited participation by SSI recipients. Public Law 93–86 had modified the provisions to relate food stamp eligibility to the amount of SSI benefits plus any State supplementary payment.) After June 1974 eligibility for food stamps will be determined under the provisions of Public Law 93–86.

Financing.—The maximum wage base will be boosted in 1974 from $12,600 (under Public Law 93–66) to $13,200. However, the contribution rate for employees will continue at 5.85 percent (the same as in 1973).

C. Status as of March 22, 1974

H.R. 11333 was signed into law (Public Law 93–233) on December 31, 1973.

7 Percent Social Security Increase (S. 2397)

A. Legislative History

Senator Church introduced S. 2397 on September 10, 1973. The bill was referred to the Senate Finance Committee.

B. Major Provisions

S. 2397 would provide an across the-board 7 percent increase in Social Security benefits, effective in January 1974. The raise would be in the nature of a substitute for the 5.9 percent cost-of-living raise (effective in June 1974) under Public Law 93–66.

C. Status as of March 22, 1974

S. 2397 was adopted in modified form as a part of H.R. 11333 (see discussion of H.R. 11333 for a description of major provisions in the bill). H.R. 11333 was signed into law (Public Law 93–233) on December 31, 1973.

Prohibition on Mailing Notices With Social Security Checks (S. 1664)

A. Legislative History

S. 1664 was introduced by Senator Church on April 30, 1973, and was referred to the Senate Finance Committee.

B. Major Provisions

S. 1664 would prohibit any material from being enclosed with any Social Security check which contains the name, signature, or title of any Federal officer other than the Commissioner of the Social Security Administration. The objective of this proposal is to prevent the Social Security mailing process from being used for narrow, partisan purposes.

C. Status as of March 22, 1974

S. 1664 is pending in the Senate Finance Committee.

Higher Payments for Working Wives (S. 868)

A. Legislative History

S. 868 was introduced by Senator Williams on February 15, 1973. It has been referred to the Senate Finance Committee.

B. Major Provisions

S. 868 would permit married couples with a working wife to compute benefits on the basis of their combined earnings record, when that method of computation produces a higher combined benefit.

C. Status as of March 22, 1974

S. 868 is pending in the Senate Finance Committee.

Unreduced Wives' and Husbands' Benefits for Disabled (S. 539)

A. Legislative History

Senator Eagleton introduced S. 539 on January 23, 1973. The bill has been referred to the Senate Finance Committee.

B. Major Provisions

S. 539 would entitle disabled wives and husbands to unreduced wife's and husband's insurance benefits without regard to age under Title II (Old-Age, Survivors', and Disability Insurance) of the Social Security Act, provided certain requirements are met.

C. Status as of March 22, 1974

S. 539 is pending in the Senate Finance Committee.

Social Security Administration Act (S. 3143 and H.R. 13411)

A. Legislative History

Senator Church introduced S. 3143 on March 11, 1974. Representative Wilbur Mills sponsored identical legislation (H.R. 13411) on March 12, 1974. S. 3143 has been referred to the Senate Finance Committee, and H.R. 13411 has been referred to the House Ways and Means Committee.

B. Major Provisions

The Social Security Administration Act has three major provisions:

1. It would establish an independent, nonpolitical Social Security Administration outside the Department of Health, Education, and Welfare. The new autonomous unit would be under the direction of a three-member governing board—appointed by the President with the advice and consent of the Senate.

2. S. 3143 would prohibit the mailing of any announcements with Social Security or Supplemental Security Income checks which make any reference whatsoever to any public officials.

3. It would remove the transactions of the Social Security trust funds from the unified budget.

C. Status as of March 22, 1974

S. 3143 is pending in the Senate Finance Committee, and H.R. 13411 is pending in the House Ways and Means Committee.

II. PROPOSALS RELATING TO RETIREMENT INCOME

Retirement Income Security for Employees Act of 1973 (S. 4)

A. Legislative History

The Retirement Income Security for Employees Act (S. 3598) was reported out by the Senate Labor and Public Welfare Committee on September 15, 1972, but no final action was taken by the Senate. It was reintroduced in the 93rd Congress as S. 4 by Senators Williams and Javits on January 4, 1973.

S. 4 was passed unanimously by the Senate on September 19, 1973. The provisions in the bill were then tacked on to a military retirement proposal (H.R. 4200) to expedite House consideration of private pension reform. The House passed its version of pension reform (H.R. 2) by an overwhelming majority of 375 to 4 on February 28, 1974.

B. Major Provisions

1. *Eligibility:* Under the Senate bill, all workers would be required to be included in a private pension plan after age 30 or one year of service, whichever occurs later. The House bill would provide for eligibility after age 25.

2. *Vesting:* S. 4 provides that a worker would acquire 25 percent vesting after 5 years of participation in a pension plan. This would increase by 5 percent a year for the next five years and 10 percent annually thereafter, until full vesting is reached after 15 years. H.R. 2 gives employers a choice of three vesting methods: (a) a worker would acquire full vested rights after 10 years of service; (b) 25 percent of benefits after five years of service gradually increased to 100 percent after 15 years (similar to the Senate bill); (c) 50 percent vesting when a worker's age and years of covered service total 45, with an additional 10 percent for each of the next five years.

3. *Plan termination insurance:* Both bills would require employers to contribute to a federally administered pension reinsurance program designed to protect workers against the loss of benefits from plans when (for example) a business failed or merged.

4. *Portability:* A voluntary portability plan which would allow workers changing jobs to transfer pension credits was included in S. 4. This was not included in the House bill.

5. *Tax deductions for retirement plans for self-employed persons (Keogh plan):* Both bills would provide an increase from the 10 percent of earned income with a $2,500 ceiling to 15 percent with a $7,500 limit.

6. *Tax deductions for retirement plans for employees not covered by pension plans:* Both bills would provide that such employees would be able to deduct a maximum of $1,500 from their pay for retirement purposes.

C. Status as of March 22, 1974

House and Senate pension reform legislation is in conference committee. Final action on the conference bill is expected, though, in 1974.

1973 Amendments to the Railroad Retirement Act

A. Legislative History

H.R. 7200 passed the House on May 22, 1973. The bill was then approved with amendments by the Senate on June 19. On June 22, the Senate agreed to the conference report on H.R. 7200. The House adopted the conference report on June 28.

B. Major Provisions

H.R. 7200 extends three temporary Railroad Retirement increases—15 percent in 1970, 10 percent in 1971, and 20 percent in 1972—from June 30, 1973 until December 31, 1974. The Act will also permit, effective July 1974, men with 30 years of railroad employment to retire on full annuities at age 60, the same as now exists for women. H.R. 7200 further provides that Railroad Retirement annuities will be increased by the same dollar amount that Social Security benefits are raised before January 1975. Moreover, the Act establishes a joint labor-management committee to submit recommendations to the Congress by April 1, 1974, for the purpose of making the Railroad Retirement program actuarially sound.

C. Status as of March 22, 1974

H.R. 7200 was signed into law (Public Law 93–69) on July 10.

III. PROPOSALS RELATING TO PROPERTY TAX RELIEF

Administration's Property Tax Relief Proposal

A. Legislative History

Secretary of the Treasury George Schultz presented the Administration's property tax relief proposal to the House Ways and Means Committee on April 30.

B. Major Provisions

The Administration's proposal would grant a property tax credit (up to $500) for homeowners 65 or older with property tax payments in excess of 5 percent of their household income. Aged renters would be entitled to a similar credit, subject to the same 5 percent floor and $500 maximum. For this purpose, 15 percent of rent would be considered property taxes. Homeowners and renters with incomes up to $15,000 could receive the full credit. Thereafter, the maximum credit of $500 would be reduced by 5 percent of household income above $15,000 until fully phased out after $25,000.

C. Status as of March 22, 1974

The House Ways and Means Committee is scheduled to mark up tax reform legislation in early 1974. At that time the Administration's property tax relief proposal will also be considered.

Emergency Property Tax Relief Act (S. 471)

A. Legislative History

Senator Church introduced S. 471 on January 18, 1973. The bill has been referred to the Senate Finance Committee.

B. Major Provisions

S. 471 would provide Federal assistance to States which establish circuit breaker systems to protect elderly homeowners and tenants from excessive property taxes and rents. A tier system would be built into the program to insure that property tax relief is targeted to those in greatest need.

C. Status as of March 22, 1974

S. 471 is pending in the Finance Committee. However, the bill will be considered when the committee acts on taxation legislation in 1974.

Property Tax Relief and Reform Act (S. 1255)

A. Legislative History

S. 1255 was introduced by Senator Muskie on March 15, 1973. The bill was referred to the Government Operations Committee. Hearings were held in May on this proposal by the Intergovernmental Relations Subcommittee of the Government Operations Committee.

B. Major Provisions

S. 1255 would provide a program of assistance to State governments to reform their real property tax laws and provide relief from excessive real property taxes for low- and moderate-income individuals. An Office of Property Tax Relief would be established in the Department of the Treasury to administer the property tax relief and reform programs. Federal assistance (equal to one-half of the cost of the program, but not more than $6 multiplied by the population of the State) would be available to States which establish a qualifying program. A State program would be required to provide relief to both homeowners and renters of residential property.

C. Status as of March 22, 1974

Hearings are planned for S. 1255 by the Intergovernmental Relations Subcommittee during 1974.

IV. PROPOSALS RELATING TO TAXATION

Administration's Age Credit Proposal

A. Legislative History

Secretary of the Treasury George Shultz presented the Administration's age credit proposal to the House Ways and Means Committee on April 30, 1973.

B. Major Provisions

The age credit would be designed to replace the retirement income credit. The computation would start with fixed dollar amounts de-

pending upon the status of the taxpayer: (a) $1,500 for a single taxpayer who is 65 or older, (b) $1,500 for taxpayers filing jointly where one spouse is 65 or older, (c) $2,250 for taxpayers filing jointly where both spouses are 65 or older, and (d) $1,125 for a married taxpayer 65 or older filing a separate return. These fixed dollar amounts would be reduced only by Social Security benefits and Railroad Retirement annuities. The earned income reduction for the retirement income credit would be eliminated.

The maximum amounts for computing the 15 percent retirement income credit are now $1,524 for single elderly persons and $2,286 for aged couples filing jointly.

C. Status as of March 22, 1974

The House Ways and Means Committee is scheduled to mark up tax reform legislation in early 1974. At that time the Administration's age credit proposal will also be considered.

Update the Retirement Income Credit (S. 1811)

A. Legislative History

Senator Church introduced S. 1811 on May 15. S. 1811 has been referred to the Senate Finance Committee.

B. Major Provisions

S. 1811 would update the retirement income credit by increasing the maximum amounts for computing the credit from $1,524 to $2,500 for an elderly single person and from $2,286 to $3,750 for an aged couple. This change alone could produce a tax savings up to $146 for single older Americans. And for an aged couple, this measure could provide an additional $220 in tax relief.

C. Status as of March 22, 1974

S. 1811 was adopted by the Senate as an amendment to H.R. 8214 on January 24, 1974. However, H.R. 8214—also with the Church amendment—was later recommitted to the Senate Finance Committee for further consideration because some controversial provisions were later added to the bill.

Older Americans Tax Counseling Assistance Act (S. 2868)

A. Legislative History

Senator Church introduced the Older Americans Tax Counseling Assistance Act on January 21, 1974. S. 2868 was referred to the Senate Finance Committee.

B. Major Provisions

S. 2868 would permit the Internal Revenue Service to strengthen the tax counseling program (Tax-Aide for the Elderly) by expanding the training and technical assistance available for volunteer tax counsultants. The Older Americans Tax Counseling Assistance Act would also permit the volunteers to be reimbursed for their actual out-of-pocket expenses incurred in training or providing assistance under the pro-

gram. Additionally, S. 2868 would authorize the IRS to conduct a retirement income credit alert to help assure that all persons eligible for this provision take advantage of this tax relief measure.

C. Status as of March 22, 1974

S. 2868 is pending in the Senate Finance Committee.

V. PROPOSALS RELATING TO HEALTH CARE

Comprehensive Health Insurance Act of 1974 (S. 2970)

A. Legislative History

CHIP was sent to the Congress by President Nixon on February 6, 1974. He said in his accompanying message that "Comprehensive health insurance is an idea whose time has come in America."

B. Major Provisions

This program would provide a system of health insurance for everyone under either an Employee Health Insurance Plan or an Assisted Health Insurance Plan. Medicare would be included in the latter but would retain most of its present administrative structure. Medicaid would be abolished except for a residual long-term care program. Benefits for everyone in the program would have to include a minimum benefit package defined in the program. Cost sharing for everyone would be related to income. The maximum payments for the first year for Medicare beneficiaries would be $750 plus premium payments.

Medicare parts A and B would be combined and there would be 20-percent coinsurance charges on all covered health services until the maximum charge is reached (see table p. 47). The current Medicare home health benefit would be reduced from 200 to 100 visits. Extended post-hospital care would be limited to 100 days per year as compared to the present provision of 100 days per benefit period or "spell of illness".

Additions to benefits currently provided under Medicare include unlimited catastrophic coverage of hospital and medical bills after the maximum liability of $750 is met (reduced for low-income persons). Out-of-hospital prescription drugs would also be included but only after a $50 deductible requirement is met. Moreover, the patient would then be subject to coinsurance charges after paying the first $50 for qualifying prescriptions. CHIP would also substantially modify the mental health benefit under Medicare. Instead of 190 lifetime days in an inpatient hospital, CHIP would cover 30 full days or 60 partial days of hospitalization per year. On an outpatient basis, there could be 30 visits to a comprehensive community care center or not over 15 visits to a private practitioner, compared with the $250 limit per year for doctor visits under Medicare. CHIP would not cover lengthy stays in nursing homes or intermediate care facilities.

C. Status as of March 22, 1974

S. 2970 has been referred to the Senate Finance Committee. Hearings are tentatively planned for 1974 on national health insurance and national health security proposals.

Home Health Medicare Amendments of 1973 (S. 2690) and Home Health Services Act of 1973 (S. 2695)

A. Legislative History

Senators Frank Church and Edmund S. Muskie introduced the above bills as a home health legislative package on November 13, 1973. The legislation was based upon recommendations to the Committee on Aging by its home health consultant Brahna Trager and testimony at hearings on "Barriers to Health Care for Older Americans."

B. Major Provisions

S. 2690 would amend the Social Security Act to provide a liberalized home health benefit under the Medicare program. It would delete the requirement that home health services may be covered only if "skilled" nursing care or physical or speech therapy is needed by the patient. Instead, beneficiaries would be eligible if they would require nursing services or any of the other home services listed in the law. In addition, the services of a part-time homemaker would be added to the list of covered services. Moreover, the number of visits authorized under both parts A and B would be increased from 100 to 200.

S. 2695 would amend the Public Health Services Act to provide for grants to assist in the establishment and initial operation of agencies which would provide home health services. Existing agencies would also be eligible for grants to add services.

C. Status as of March 22, 1974

A total of 26 senators are sponsoring S. 2690 and 25 senators S. 2695. The latter is expected to be considered in April 1974 by the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. S. 2690 has been referred to the Senate Committee on Finance and no hearing date has been set. In the House, companion legislation has been introduced by Congressman Donald M. Fraser (H.R. 11965 and H.R. 11966). H.R. 11965 which authorizes the grant program has been referred to the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce and H.R. 11966 has been referred to the Ways and Means Committee.

Health Maintenance Organizations and Resource Development Act (S. 14)

A. Legislative History

Senator Kennedy introduced S. 14 on January 4, 1973. This bill was similar to S. 3327 which had passed the Senate in 1972. A scaled down version of S. 14 was passed by the Senate on May 15, 1973 and was further amended by the House on September 12, 1973. The House and Senate agreed to the conference report on S. 14 on December 18 and 19, respectively.

B. Major Provisions

S. 14 provides financial aid to public and nonprofit organizations through grants, contracts and loans to develop and expand health maintenance organizations (HMO's). An HMO is a medical organiza-

tion which provides complete medical services for its members for a regular fee. The assistance may be used for feasibility and planning studies, initial development costs, and initial operating deficits of HMO's for the first three years.

Included in the Act is a list of benefits which must be offered by the HMO's in order to receive assistance, such as preventive services, inpatient and outpatient hospital services, mental health services, home health services, and emergency services. Two important provisions which are expected to facilitate HMO development are (1) the preemption of restrictive State laws which have impeded their development and (2) the requirement that employers of 25 or more employees must offer an HMO option if other types of health benefits are offered employees and if an HMO is operating in the area.

The Act authorizes $375 million in funding over a 5-year period.

C. Status as of March 22, 1974

The President signed the compromise bill into law (Public Law 93–222) on December 29, 1973. Regulations are being prepared in the Department of Health, Education, and Welfare to implement the program.

Catastrophic Health Insurance and Medical Assistance Reform Act (S. 2513)

A. Legislative History

Senators Long and Ribicoff introduced S. 2513 on October 2, 1973. It incorporates S. 1416 introduced by Senator Long on March 29, 1973. The bill was referred to the Committee on Finance.

B. Major Provisions

The legislation consists of two parts: (1) A Catastrophic Illness Insurance Program and (2) A Medical Assistance Plan for Low-Income People. The catastrophic proposal would cover the same kinds of services currently provided under parts A and B of Medicare except that there would be no upper limitations on hospital days or home health visits. All persons insured by Social Security, their spouses and dependents, and Social Security beneficiaries would be eligible for this protection. However, benefits would start only after an individual was hospitalized 60 days in one year or after family medical expenses of $2,000. After these conditions had been met, benefits would be payable as under Medicare which provides for coinsurance payments beyond 60 days of hospitalization and for all medical services. Coinsurance charges would be limited to $1,000 for all persons including Medicare beneficiaries.

The Medicare program would be continued, but with the addition of the limitation on coinsurance payments for prolonged illnesses. Moreover, the bill would provide for coverage of immunization and pap smears for Medicare beneficiaries.

The Medical Assistance Plan for Low-Income People would replace the existing State-Federal Medicaid program. States would be left to provide uncovered services, such as eyeglasses, hearing aids, drugs and dental services with the Federal Government providing half the cost. For low-income older Americans, the bill would pay for part B

Medicare premiums as well as Medicare coinsurance and deductible charges. In addition, it would provide them with all medically necessary hospital, skilled nursing facility and intermediate care facility services. Home health care would also be available without limitation.

Income limits for eligibility would be $2,400 for an individual and $3,600 for a couple. A copayment of $3 would be required on patient-initiated services, such as visits to a doctor's office, but copayments could not exceed $30 per individual or family during a year. Copayments would be based on the amount of a patient's income less $50 after an individual had been institutionalized for 60 days in a long-term care facility.

C. Status as of March 22, 1974

The Long-Ribicoff bill has been referred to the Committee on Finance where it is pending. No date has as yet been set for a hearing. However, hearings are tentatively planned for 1974, as a part of the Committee's inquiry into national health insurance and national health security proposals.

VI. PROPOSALS RELATING TO LONG-TERM CARE

Inservice Training for Nursing Home Personnel (S. 512)

A. Legislative History

S. 512 was introduced by Senator Frank E. Moss on January 23, 1973. The bill has been referred to the Senate Labor and Public Welfare Committee.

B. Major Provisions

S. 512 would amend the Public Health Service Act to provide inservice training to nursing home personnel.

C. Status as of March 22, 1974

S. 512 is pending before the Labor and Public Welfare Committee.

Loans for Nursing Home Fire Safety (S. 513)

A. Legislative History

S. 513 was introduced by Senator Moss on January 23, 1973. The bill passed the Senate on November 30, 1973 and the House on December 17, 1973.

B. Major Provisions

The bill amends section 232 of the National Housing Act to authorize insured loans for the purchase of fire safety equipment for nursing homes. The Secretary of Housing and Urban Development is vested with authority to set the mortgage limit, the interest rate and terms of the loans.

C. Status as of March 22, 1974

S. 513 was signed into law (Public Law 93–204) by President Nixon on December 28, 1973.

Increasing the Emphasis on Geriatrics in Schools of Medicine (S. 764)

A. Legislative History

S. 764 was introduced by Senator Moss on February 5, 1973.

B. Major Provisions

The bill would provide grants to six schools of medicine selected by the Secretary of Health, Education, and Welfare to assist them in establishing and operating departments of geriatrics.

C. Status as of March 22, 1974

S. 764 is pending before the Senate Committee on Labor and Public Welfare.

Training Paramedical Personnel to Work in Nursing Homes (S. 765, S. 766, and S. 2052)

A. Legislative History

On February 5, 1973, Senator Moss introduced S. 765 and S. 766 and joined Senator Frank Church on June 22 in introducing S. 2052.

B. Major Provisions

S. 765 would amend the Public Health Service Act to provide for the training of certain veterans with appropriate experience as medics to serve as medical assistants in long-term care facilities. S. 766 would provide grants to appropriate colleges and universities to assist them in the establishment and operation of programs to train physician's assistants. S. 2052 would provide funds to schools of nursing to establish programs to create nurse practitioners and prepare them to serve in U.S. nursing homes.

C. Status as of March 22, 1974

All three bills are pending before the Senate Committee on Labor and Public Welfare.

Making Nursing Home Care Available (S. 1825)

A. Legislative History

On May 16, 1973, Senator Moss introduced S. 1825.

B. Major Provisions

The bill would broaden the scope of the Medicare program to authorize comprehensive nursing home benefits, including expanded skilled nursing services, and intermediate care. In addition, it would expand the eligibility for home health services and would authorize day care.

C. Status as of March 22, 1974

The bill is pending before the Senate Finance Committee.

VII. PROPOSALS RELATING TO HOUSING

Williams Omnibus Housing Package for the Elderly (S. 2179, S. 2180, S. 2181, S. 2185)

A. Legislative History

Senator Harrison A. Williams introduced a major package of four housing bills for the elderly on July 13 and 14, 1973.

B. Major Provisions

1. S. 2179 would establish a demonstration direct loan program for housing for the elderly by creating a National Elderly and Handicapped Housing Loan Fund. The structure of the program would be based on the Section 236 Multifamily Program, and the receipts and proceeds of the loan fund would not be included in the Federal Budget.

2. S. 2180 would establish an Office of Security at HUD and would authorize funding specifically earmarked for programs designed to prevent crime in HUD-assisted housing projects.

3. S. 2181 would establish an interest-subsidy program (patterned after the Section 236 program) to provide funding for "intermediate" housing for the elderly. Funds would be made available for sponsors to convert existing single-family housing into efficiency units in the vicinity of a multi-supportive service center to provide an alternative to institutional care.

4. S. 2185 would revitalize the Section 202 housing program by increasing the authorization level by $100 million.

C. Status as of March 22, 1974

The Housing Subcommittee of the Senate Banking, Housing and Urban Affairs Committee incorporated the provisions of the Williams package into its major legislative bill, S. 3066, with some changes (see discussion of S. 3066 below).

The Housing and Community Development Act of 1974 (S. 3066)

A. Legislative History

For several months in 1973 and early 1974, Senator John Sparkman's Housing Subcommittee considered a wide variety of bills on housing and community development. In early February 1974 they approved a large composite bill that included many different proposals. When this bill was reported out of committee to the Senate floor, it received a clean number, S. 3066.

B. Major Provisions

The Williams Housing Package:

1. S. 2179 and S. 2180 were combined to form a revised and renewed Section 202 housing program with a new National Elderly and Handicapped Housing Loan Fund. This fund would include the old revolving fund. The Secretary of the Treasury would be authorized to borrow money for the fund ($100 million for fiscal year 1975). All receipts and disbursements would be excluded from the Federal budget. An annual appropriation would be required to make up the difference between the 3 percent 202 loans and the interest paid on the Treasury

borrowings. Companion legislation (H.R. 13301) for this program was introduced in the House by Congresswoman Boggs.

2. S. 2180, the Housing Security Act of 1973, was included in full in this bill. It would establish an Office of Security at HUD and authorize $10 million for fiscal year 1975 for security programs in HUD-assisted housing.

3. S. 2181 was not included in the bill. However, the report of the Banking, Housing and Urban Affairs Committee on S. 3066, indicates the committee's approval of intermediate housing as an important concept that should be expanded (see discussion of S. 2181 above).

Other Provisions Affecting the Elderly:

1. New Construction of Traditional Public Housing was included at the level of $175 million.

2. Section 236 Housing would be resumed under Section 502 of the bill. Not less than 15 percent nor more than 25 percent of Section 502 funding is set aside for the elderly.

3. Supplementary loans are made available under Section 502 to expand common facilities for outreach services to the community.

4. Public Housing authorities would be permitted to earmark up to 10 percent of their new construction funds for projects with central dining facilities.

C. Status as of March 22, 1974

S. 3066 passed the Senate on March 11, 1974, and now awaits action by the House on their major legislation. The House is marking up housing and community development bills at this time.

Full Benefits for Elderly Tenants Act (S. 1322)

A. Legislative History

Senator Williams introduced the Full Benefits For Elderly Tenants Act on March 22, 1973. The bill was referred to the Banking, Housing and Urban Affairs Committee.

B. Major Provisions

The bill would require the Secretary of HUD to disregard the increase in benefits under the 20-percent Social Security raise passed pursuant to Public Law 92–336. The 20-percent Social Security increase would not be considered in determining an elderly person's rent or income eligibility for Public Housing and other housing programs.

C. Status as of March 22, 1974

The bill is still pending before the Housing Subcommittee.

VIII. PROPOSALS RELATING TO THE OLDER AMERICANS ACT

Older Americans Comprehensive Services Amendments (S. 50)

A. Legislative History

Senator Eagleton introduced S. 50 (the Older Americans Comprehensive Services Amendments) on January 4, 1973. Eventually 66 members of the Senate joined Senator Eagleton as cosponsors of the

proposal. Companion legislation (H.R. 71) was introduced in the House of Representative John Brademas on January 3, 1973. The Senate approved S. 50 on February 20, 1973, by a vote of 82 to 9. Similar legislation was approved by the House on March 13, 1973, by a vote of 329 to 69. On April 18, 1973 the Senate agreed to the House amendments with further amendments. Hours later, the House adopted the proposal by a vote of 348 to 0. As approved by the Congress, the Older Americans Comprehensive Services Amendments included every substantive program incorporated in the legislation pocket-vetoed by the President in October 1972 (See "Developments in Aging: 1972 and January-March 1973", p. 53).

B. Major Provisions

S. 50 made major changes and innovations in the Older Americans Act. 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 the (a) interrelationship of programs for the elderly and (b) the combined impact of all taxes affecting the aged.

Strengthening of the Administration on Aging.—Two fundamental changes were incorporated in S. 50 to strengthen the Administration: (1) AoA was transferred out of the Social and Rehabilitation Service to the Office of the Secretary of HEW; and (2) the Secretary was precluded from approving any delegation of functions of the Commissioner of AoA to any other officer not directly responsible to the Commissioner unless the Secretary shall first submit a delegation plan to the Congress for approval.

Model Projects.—A new model projects program was established to develop innovative solutions for some of the everyday problems confronting the elderly, including housing, preretirement counseling, continuing education, and social services for handicapped elderly Americans.

Title III Grants for State and Area Programs.—The title III program was remodeled to provide comprehensive and coordinated social services delivery systems through the establishment of planning and service areas.

Multipurpose Senior Centers.—Federal funding was also authorized for acquiring, altering, or renovating facilities to be used for multipurpose senior centers.

Foster Grandparents.—The concept of the Foster Grandparent program was expanded under the bill to include supportive services to children and adults in community settings, as well as services for institutionalized children.

The bill authorized $543.6 million plus "such sums as may be necessary" 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). The effect of this language is that the President will propose such amounts as he deems necessary, and then the Congress will act on these budgetary requests.

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

Authorized funding levels for older Americans comprehensive services amendments (S. 50)

[Dollars in millions]

	Fiscal year—		
	1973	1974	1975
Title II:			
National information and resource clearinghouse	[1]	[1]	[1]
Title III:			
Area planning and social services	[1]	$103.6	$130
Administration	[2]	[2]	[2]
Model projects	[1]	[1]	[1]
Title IV:			
Training	[1]	[1]	[1]
Research	[1]	[1]	[1]
Special transportation R. & D	[1]	[1]	[1]
Title V:			
Multipurpose senior centers	[1]	[1]	[1]
Annual interest grants	[1]	[1]	[1]
Personnel staffing grants	[1]	[1]	[1]
Title VI:			
RSVP	$15	17.5	20
Foster grandparents	25	32.5	40
Title VII:			
Nutrition program (authorized in Public Law 92-258)			
Title VIII:			
Older reader services	[1]	[1]	[1]
Special programs (Title I, Higher Education Act)	[1]	[1]	[1]
Senior opportunities and services	[1]	[1]	[1]
Title IX:			
Community service employment		60.0	100
Total	40	213.6	[3] 290

[1] Open ended authorization (such sums as may be necessary for carrying out the purposes of the program).
[2] Included in authorized funding for area planning and social services.
[3] Total 3-year authorization $543,600,000.

C. Status as of March 22, 1974

S. 50 was enacted into law (Public Law 93-29) on May 3, 1973.

Extension of Nutrition Program for the Elderly (S. 2488 and H.R. 11105)

A. Legislative History

On September 26, 1973, Senator Kennedy and Senator Percy introduced S. 2488. Similar legislation (H.R. 11105) was introduced in the House by Representatives Brademas and Pepper on October 25,

1973. The House approved H.R. 11105 on March 19, 1974 by a vote of 380 to 6.

B. Major Provisions

S. 2488 would extend the Nutrition Program for the Elderly (Title VII of the Older Americans Act) for three years: $150 million for fiscal 1975, $175 million for fiscal 1976, and $200 million for fiscal 1977. As approved by the House, H.R. 11105 would authorize $600 million over a three-year period for the Title VII Nutrition Program—$150 million for fiscal 1975, $200 million for fiscal 1976, and $250 million for fiscal 1977.

C. Status as of March 22, 1974

The Subcommittee on Aging of the Senate Labor and Public Welfare Committee expects to conduct hearings on proposals to extend the Title VII program in early April.

Extension of the Nutrition Program for the Elderly (S. 3100)

A. Legislative History

Senator Beall sponsored S. 3100 on March 4, 1974.

B. Major Provisions

S. 3100 would extend the Title VII Nutrition Program for one year with "open-ended" authorization.

C. Status as of March 22, 1974

(See preceding discussion of S. 2488 above.)

IX. PROPOSALS RELATING TO AGE DISCRIMINATION AND MANPOWER PROGRAMS FOR OLDER WORKERS

Age Discrimination in Employment Act Amendments (S. 1810)

A. Legislative History

Senator Church introduced S. 1810 on May 10, 1973. The provisions in S. 1810, as well as S. 635 (see discussion below), were incorporated in S. 1861 (the Fair Labor Standards Amendments), which passed the Senate on July 20, 1973. These measures were later deleted in conference committee because of the House germaneness rule. The Fair Labor Standards Amendments were later vetoed by President Nixon on September 6, 1973. The House sustained the Presidential veto on September 19, 1973. The basic provisions of S. 1810 and S. 635 were again incorporated in a new Fair Labor Standards Amendments bill (S. 2747), which passed the Senate on March 7, 1974. The House also included the Age Discrimination in Employment Act Amendments in its version of the Fair Labor Standards Act Amendments (H.R. 12435). The House passed H.R. 12435 on March 20, 1974.

B. Major Provisions

The Age Discrimination in Employment Act Amendments would (1) broaden the application of the Act to include Federal, State, and local governmental employees; (2) increase the authorized funding level from $3 million to $5 million; and (3) extend the Act to private

employers in interestate commerce with 20 or more employees (instead of 25 as under present law).

C. Status as of March 22, 1974

The Fair Labor Standards Amendments legislation is in conference committee. The Age Discrimination in Employment Amendments will be included in the conference bill because the House and Senate adopted identical provisions in their versions of the Fair Labor Standards Amendments.

Age Discrimination in Employment Act Amendments (S. 635)

A. Legislative History

Senator Bentsen introduced S. 635 on January 31, 1973. (For more detailed description, see preceding discussion of S. 1810 above.)

B. Major Provisions

S. 635 would extend the Age Discrimination in Employment Act to include Federal, State, and local governmental employees. Additionally, it would increase the authorized funding level from $3 million to $5 million.

C. Status as of March 22, 1974

(See preceding discussion of S. 1810 above.)

Older American Community Service Employment Act
(Title IX of S. 50)

A. Legislative History

The Older American Community Service Employment Act was incorporated in S. 50, which was introduced by Senator Eagleton on January 4, 1974. The original Older American Community Service Employment Act was introduced by Senator Kennedy in March 1970.

(See preceding discussion of S. 50 for more detailed information, on p. 171.)

B. Major Provisions

Title IX established a national senior service corps to provide new job opportunities in a wide range of community service activities for low-income persons 55 or older.

C. Status as of March 22, 1974

(See preceding discussion of S. 50 for more detailed information, on p. 173.)

Middle-Aged and Older Workers Training Act (Title X of S. 50)
(Later Added as an Amendment to S. 1559)

A. Legislative History

The Middle-Aged and Older Workers Training Act was incorporated as Title X in S. 50. Senator Randolph introduced the original version of the Middle-Aged and Older Workers Training provisions in October 1968.

Title X was deleted from the Older Americans Comprehensive Services Amendments by the House in March 1973.

(See preceding discussion of S. 50 for more detailed information, on p. 171.)

Key features of Title X were later added by Senator Randolph as an amendment to S. 1559, which eventually became the Comprehensive Employment and Training Act. S. 1559 passed the Senate on July 24, 1973. A similar bill (H.R. 11010) was approved by the House on November 28, 1973. House and Senate conferees agreed to the Randolph Amendments in modified form. On December 20, the House and Senate agreed to the conference report on S. 1559.

B. Major Provisions

The Randolph Amendments authorize Federal funding for special employment services for middle-aged and older workers, including placement, recruitment, and counseling for persons who are unemployed because of a plant shutdown or other permanent large-scale reduction in the work force. Additionally, the Amendments authorize the Secretary of Labor to make grants or enter into contracts with prime sponsors to help middle-aged and older workers obtain part-time or temporary employment.

C. Status as of March 22, 1974

S. 1559—along with the Randolph Amendments—became law (Public Law 93–203) on December 28, 1973.

"National Employ the Older Worker Week" (S.J. Res. 49 and H.J. Res. 334)

A. Legislative History

Senator Randolph introduced S.J. Res. 49 on February 2, 1973. Representative John Brademas sponsored companion legislation (H.J. Res. 334) on February 8, 1973. H.J. Res. 334 passed the House and Senate on March 12, 1973.

B. Major Provisions

H.J. Res. 334 authorized the President to designate the second full week in March of 1973 as "National Employ the Older Worker Week."

C. Status as of March 22, 1974

H.J. Res. 334 was enacted into law (Public Law 93–10) on March 15, 1973.

X. PROPOSALS RELATING TO RESEARCH AND TRAINING

Older Americans Comprehensive Services Amendments (S. 50)

A. Legislative History

(See preceding discussion of S. 50, page 171.)

B. Major Provisions

S. 50 provided an "open-ended" authorization 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.

Additionally, S. 50 made Federal funds available for attracting qualified persons to the field of aging by (a) publicizing available opportunities for careers in aging; (b) encouraging qualified persons to enter or reenter the field, (c) encouraging artists, craftsmen, scientists and homemakers to undertake assignments on a part-time basis or for temporary periods in the field of aging; and (e) preparing and disseminating materials for recruitment and training of individuals.

The Act also authorized the Commission to make grants or enter into contracts for the purpose of (a) studying current living conditions of older persons and identifying factors which are beneficial or detrimental to the wholesome and meaningful living of the elderly (b) developing approaches for improving conditions of community services for older Americans, and (c) evaluating various methods to assist the elderly enjoy wholesome and meaningful lives, as well as continuing to contribute to the strength and welfare of our Nation.

C. Status as of March 22, 1974

(See preceding discussion of S. 50, page 173.)

Research on Aging Act (S. 775)

A. Legislative History

Senator Eagleton introduced S. 775 (the Research on Aging Act) on February 6, 1973. Companion legislation (H.R. 65 and H.R. 6175) was introduced by Representative Rogers in the House on January 3, 1973 and March 27, 1973, respectively. H.R. 6175 was reported out of the House Interstate and Foreign Commerce Committee on March 7, 1974.

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 suporting biomedical, social, and behavioral research and training relating to the aging process.

C. Status as of March 22, 1974

The Research on Aging Act is awaiting action by the House.

XI. PROPOSALS RELATING TO HEARING AIDS

Medicare Coverage for Hearing Aids (S. 436)

A. Legislative History

Senator Hartke sponsored S. 436 on January 18, 1974. S. 436 was referred to the Senate Finance Committee.

B. Major Provisions

S. 436 would extend Medicare coverage to include hearing aids (as well as eyeglasses, dentures, eye care, and dental care).

C. Status as of March 22, 1974

S. 436 is pending in the Senate Finance Committee.

XII. PROPOSALS RELATING TO TRANSPORTATION

Special Transportation Projects Relating to Older Americans (Section 412 of S. 50)

A. Legislative History

Provision for a special transportation demonstration program for older Americans was incorporated in S. 50 as section 412 of the bill. Senator Williams was the original author of the transportation measure (the Older Americans Transportation Services Development Act) in 1970.

(See preceding discussion of S. 50 for more detailed information, on p. 171.)

B. Major Provisions

Section 412 authorizes a special study 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.

C. Status as of March 22, 1974

(See preceding discussion of S. 50 for more detailed information, on p. 173.)

Federal-Aid Highway Act of 1973 (S. 502)

A. Legislative History

Senator Bentsen sponsored the Federal-Aid Highway Act Amendments (S. 502) on January 23, 1973. S. 502 passed the Senate on March 15, 1973. The House approved similar legislation on April 19, 1973. The conference report on the bill was adopted in the Senate on August 1 and in the House on August 3.

B. Major Provisions

S. 502 included a number of measures of direct importance to aged and handicapped Americans. Among the key provisions:

1. An authorization of $65 million to help assure that the Washington Metropolitan Area Transit Authority is accessible to the handicapped.
2. Authority for the Secretary of Transportation to fund rural highway public transportation demonstration programs.
3. An increase in the amount of funds that the Secretary of Transportation can allocate (from 1½ to 2 percent of the amount authorized under the Urban Mass Transportation capital grant program) for assisting State and local transit authorities in providing transportation services to meet the special needs of elderly and handicapped persons.

C. Status as of March 22, 1974

The Federal-Aid Highway Act of 1973 was signed into law (Public Law 93–87) by President Nixon on August 13, 1973.

XIII. PROPOSALS RELATING TO THE MINORITY AGED

Social Security Amendments (H.R. 7445)

A. Legislative History

(See discussion of H.R. 7445 on p. 157.)

B. Major Provisions

Retirement test liberalized.—The annual earnings limitation for persons under age 72 increased (effective January 1974) from $2,100 to $2,400. For earnings in excess of this amount, $1 in benefits will be withheld for each $2 of earnings. This measure will provide an additional $200 million in benefits for calendar year 1974 for approximately 1.5 million beneficiaries.

Covering "essential persons".—Eligibility for SSI payments will also extend to so-called "essential persons" (effective in January 1974). Essential persons are generally wives of eligible aged recipients who have themselves reached age 65. In practically all States, some recognition was given to their needs under prior Old Age Assistance programs. An estimated 125,000 persons (mostly wives under age 65) will receive additional Federal payments under this provision.

State supplementation required.—Assurance is also provided that aged, blind, and disabled persons on the welfare rolls in December 1973 will not lose income because of the federalized Supplemental Security Income program. State supplementation will be required up to present assistance levels, except for Texas which cannot provide supplementation under its Constitution.

90–10 rule repealed.—An amendment, sponsored by Senator Frank Church was adopted to repeal the 90–10 rule concerning social services for the aged, blind and disabled under the Social Security Act. Under the Revenue Sharing Act, at least 90 percent of a State's allotment must be directed toward current welfare recipients, and only 10 percent can be targeted for past and potential beneficiaries. The Church Amendment will allow greater flexibility in providing social services for former and potential adult welfare recipients.

C. Status as of March 22, 1974

(See discussion of H.R. 7445 on p. 158.)

Social Security Amendments of 1973 (H.R. 11333)

A. Legislative History

(See discussion of H.R. 11333 on p. 158.)

B. Major Provisions

Two-step, 11 percent increase.—Nearly 30 million Social Security beneficiaries will receive a two-step, 11 percent increase: the first stage will be an interim seven percent raise (effective for March 1974) which

will be a partial advance payment on a permanent 11 percent increase (effective for June 1974). This action—together with three other across-the-board raises since December 1969—means that Social Security benefits will be boosted by 68.5 percent in a 4½ year period. Of special significance, H.R. 11333 will help remove an estimated 800,000 Americans from the poverty rolls, including 500,000 in the 65-plus age category. In terms of individual monthly benefits, H.R. 11333 will have the following impact:

	Before 7 percent increase	After 7 percent increase	After 11 percent increase
Average monthly benefits:			
Retired worker alone	$162	$173	$181
Retired couple	277	296	310
Aged widow alone	158	169	177
Monthly benefits for other beneficiaries:			
Minimum, retired worker alone	84.50	90.50	93.80
Minimum, retired couple	126.80	135.80	140.70
Maximum, retired male worker in 1974	274.60	293.90	304.10
Maximum, retired couple	411.90	439.70	457.40

Special minimum monthly benefit.—Under present law, the special minimum monthly benefit is equal to $8.50 multiplied by the number of years of covered employment in excess of 10 years but not greater than 30 years. H.R. 11333 will increase the multiple from $8.50 to $9.00 in March 1974.

Supplemental Security Income standards.—Monthly income standards for the new Supplemental Security Income program (effective in January 1974) were raised from $130 to $140 for eligible individuals and from $195 to $210 for qualifying couples. A further increase will be provided in July 1974: to $146 for single persons and $219 for couples.

Food Stamp Eligibility Restored for SSI Recipients.—Food stamp and surplus commodities eligibility was restored for SSI recipients on the basis of income and asset requirements of the programs. This eligibility will be effective from January to June 1974. Then it is anticipated that further legislation will be enacted to deal with this subject matter.

C. Status as of March 22, 1974

(See discussion of H.R. 11333 on p. 159.)

MINORITY VIEWS

MINORITY VIEWS OF MESSRS. FONG, HANSEN, GURNEY, BROOKE, PERCY, STAFFORD, BEALL, DOMENICI, AND BROCK

It has been our custom in the annual Special Committee on Aging Minority Reports since 1961 to review progress and make specific recommendations for improvement in national efforts to meet needs of older Americans. This year, instead, we raise some questions to which neither society, nor government, has given proper attention.

We reiterate our support of the positive philosophy of aging inherent in our previous recommendations. We endorse continued effort to enact our proposals which have not yet been accepted and further action on those which have been fulfilled only partially.

Even as we press for prompt action on immediate needs of older persons, we believe that truly acceptable policies in aging are unlikely of fulfillment until Americans of all ages understand how questions such as we shall raise here affect them collectively and individually throughout life.

Our decision to emphasize now a plea for public attention to *questions* comes in part from our belief that the issues too long have been the special province only of older persons themselves or of professionals in aging and other narrow disciplines. In no way is it to be construed as minimizing our concern for immediate and serious problems now facing the elderly.

On the contrary, we believe that America's debt to its aged is overdue and should be paid as rapidly as practical. But all of the specific problems in aging—income adequacy, health care, housing, transportation, social involvement, work opportunities, social services and a host of others—must be examined in the broad context of life-quality goals for all citizens and recognition that THE issue in aging is the right of older Americans to fully-equal status in our national community. We believe this issue has not been faced squarely by society.

MOST IMPORTANTLY THE NATION HAS FAILED TO RECOGNIZE THE INDIVIDUALITY OF ITS 21 MILLION CITIZENS PAST 65. Responsibility for this failure must be accepted by leaders in the non-governmental sector of national life and by government agencies at all levels. Both private and public forces that influence individual destinies have too long ignored positive elements in aging brought by the 20th century.

Full review of the questions we raise is imperative to a proper response to problems faced by older Americans today. Intelligent answers to them are equally essential if today's young and middle-aged Americans are to avoid for themselves the type of second class citizenship which too often faces their seniors today.

America should address the questions with recognition that all of life is a continuum—A CONTINUUM CHARACTERIZED BY CHANGE, BUT ONE WHICH SHOULD NOT INVOLVE SHARP DIVISION AND SEGREGATION OF PERSONS BY REASON OF AGE.

It is not enough that many older Americans do have satisfying lives in society. There are millions to whom opportunity for this basic right is denied. This denial probably will continue as long as we pursue segregation based on age, push the elderly outside of America's mainstream and fail to respond adequately to their needs as individual citizens.

RECENT PROGRESS

Re-direction of attention to broad questions in aging is particularly appropriate now in view of major positive specific actions on behalf of older Americans in recent years.

Substantial forward steps during the past year have included:

(1) Social Security benefit increases of 11 percent, continuing a process which has brought an increase of 67.5 percent in the past 4 years and 100.7 percent during the past 10.

(2) A new Supplemental Security Income (SSI) program has been inaugurated, which offers a federally guaranteed monthly income of $140 per individual and $210 per couple past 65. FOR THE MORE THAN TWO-THIRDS OF THE ELDERLY WHO RECEIVE REGULAR SOCIAL SECURITY BENEFITS, RESPECTIVE MONTHLY INCOME GUARANTEES FOR INDIVIDUALS AND COUPLES ARE $160 AND $230. Because $65 of monthly earned income is disregarded (and half of earnings above $65), the Federal supplement can raise income levels subject to SSI to over $225, individual and $295, couple. All of these monthly income levels will rise $9 effective June 1, 1974.

(3) The federally financed hot meal service—in congregate settings and with delivery to home-bound individuals—has been expanded so as to provide five meals a week to approximately 200,000 older persons.

(4) H.R. 3153, in conference between the Senate and the House of Representatives to resolve differences, offers further Social Security Act amendments, including improvements in Medicare.

(5) Private pension reform legislation in H.R. 2, likewise in conference promises significant improvement in non-governmental efforts to provide retirement income with safety and equity.

Action in aging during the past 10 or 20 years, particularly since the Eisenhower White House Conference on Aging in 1961, shows a growing public awareness of the "problem of aging." This is far from surprising with 15 percent of the adult population now over 65 and 36 percent over 50.

"The problem of aging" receives increasing attention from individuals, discussions by communications media, and action programs by various organizations. Often the ideas emerging from public concern with the "problem of aging" unfortunately have been at cross purposes, have ignored root causes of the "problem" and valid concepts of what older persons are or want.

Three Basic Questions

WHAT IS NEEDED NOW IS A NEW LOOK AT AGING TO DEVELOP A NEW NATIONAL SOCIAL AND ECONOMIC POLICY WHICH WILL OFFER ALL OLDER AMERICANS MAXIMUM OPPORTUNITY FOR INDEPENDENT LIVING WITH DIGNITY, COMFORT, HONOR, AND FREEDOM OF CHOICE.

Equality of status for older persons must be the key ingredient. This should carry with it all the rights and life-style alternatives inherent in first class American citizenship. Intensified public attention should be given to three basic questions:

I. *How can expression of their singular personality by the 20 to 30 million older Americans be strengthened through wide individual opportunities for satisfying life roles?*

II. *How can America's private sector and government at various levels meet their several responsibilities for expanding freedom of choice by older Americans in society's economic and social life?*

III. *How can the people as a whole, young and old, come to awareness of new 20th century implications of aging in relationship to social policies and their own individual needs throughout life?*

Our attitude is reflected in two key words which appear in each of our three initial questions: *individual* and *life*. We abhor the too prevalent practice of looking at older Americans as statistics or objects of obsolescence. As long as there is *life*, there is *individuality*. Social rejection of persons because of age is indefensible even in a "throw-away" society.

SOLUTIONS OF AMERICA'S "PROBLEM OF AGING" DEMAND A NEW SOCIAL CONSCIOUSNESS BASED ON FACTS, ON THE BEST AVAILABLE PROFESSIONAL OPINIONS AND ON UNDERSTANDING OF OLDER AMERICANS' OWN GOALS IN LIFE.

OPPORTUNITY FOR SATISFYING LIFE-ROLES

I. *How can expression of their singular personality by the 20 to 30 million older Americans be strengthened through wide individual opportunity for satisfying life roles?*

As the Nation addresses itself to this question it is important to emphasize its *plurality*. Too often national policies, as laid down in public laws and as set forth in social and economic custom *with sometimes even more devastating effect*, have been developed as if there should be a *single role* for older persons. Short of total neglect, nothing in aging is more injurious to the interests and needs of either the nation or its elders than this over-simplification.

It is true that there are special problems which face many older Americans for which valid group responses must be developed, but such group responses should take into account the individual variations among those past 65—variations which may be greater than those within any other age group.

In this connection quotation from the Report by the Retirement Roles and Activities Section to delegates of the 1971 White House Conference on Aging appears appropriate. The introduction and recommendations of this section report said:

> As we grow older, we continue to need to occupy roles that are meaningful to society and satisfying to us as individuals. However,

we emphasize the primacy of such basic necessities as income, health and housing and these needs must be adequately met.

Twenty million older people with talents, skills, experience and time are an inexhaustible resource in our society. We represent all segments of the population; our abilities, our education, our occupational skills, and our cultural backgrounds are as diverse as America itself.

Given proper resources, opportunities and motivation, older persons can make a valuable contribution. We are also capable of being effective advocates of our own cause and should be included in planning, in decision making and in the implementation of programs. Choice of roles must be available to each older person despite differences in language and ethnicity, and limitation because of disability or level of income. The lives of Americans of all ages will be enriched as the Nation provides opportunities for developing and utilizing the untapped resources of the elderly.

RECOMMENDATIONS

1. Society—through government, private industry, labor, voluntary organizations, religious institutions, families and older individuals, must exercise its responsibility to create a public awareness of changing life styles and commitments in a continuous life cycle. Together they should discover and implement social innovations as vehicles for older persons to continue in, return to, or assume roles of their choice. These innovations should provide meaningful participation and leadership in government, cultural activities, industry, labor, welfare, education, religious organizations, recreation and all aspects of volunteer service.

2. Program efforts to meet role problems and to create new role opportunities should be designed to serve all segments of the older population. Priorities should be determined according to local and individual needs; special effort must be made to include persons who might otherwise be excluded—the impoverished, the socially isolated, the ethnic minorities, the disabled and the disadvantaged.

3. Society should adopt a policy of preparation for retirement, leisure, and education for the life off the job. The private and public sections should adopt and expand programs to prepare persons to understand and benefit from the changes produced by retirement. Programs should be developed with government at all levels, educational systems, religious institutions, recreation departments, businesses and labor to provide opportunities for the acquisition of the necessary attitudes, skills and knowledge to assure successful living. Retirement and leisure time planning begins with the early years and continues through life.

No one would quarrel with the essential need for income adequate to purchase the necessities of life nor with the need for access to goods and services necessary to quality in life—food, housing, medical care, social opportunities. The real question is: "How can we meet these obvious common needs without creating new barriers to individual fulfillment, without so segregating older Americans that they become second class citizens or virtual wards of the State?"

The Goal: Fulfillment of Individual Purpose

ANY DISCUSSION OF ECONOMIC AND SOCIAL ROLES OF OLDER AMERICANS MUST BEGIN WITH SENSITIVITY TO THEIR LIFE-LONG HOPES AND OBJECTIVES. IT MAY BE THAT THE MORE MODEST THEY ARE, THE GREATER ATTENTION THEY SHOULD RECEIVE. THERE SHOULD BE A DELIBERATE CONSCIOUSNESS OF THE ELDERLY AS PERSONS WHO HAVE DIFFERING PURPOSES IN LIFE. OUR NATIONAL PURPOSE SHOULD AIM AT FULFILLMENT OF INDIVIDUAL PURPOSE.

It is appropriate, therefore, to look at some of the kinds of dreams which older Americans have had. What clues may they offer, even in their variations, to sound national policies in aging? To what extent have dreams of the past been achieved? To what extent have aging policies created barriers to their fulfillment? Are there common factors to which, nonetheless, different kinds of responses should be made?

For many, but not all, the dream has included ownership of a home, free and clear. What is our responsibility to the many who succeeded? How can we meet the problem of rising property taxes which now threatens hundreds of thousands who have attained this goal? With whom does responsibility for appropriate answers rest?

How do Federal tax laws impede free use of assets in homeownership by the old? How serious a problem is such inflexibility? When an older married couple, who have placed all their life savings in purchase of a home adequate for a growing family, finds it appropriate to sell that home and purchase a smaller one or use the savings it represents in other beneficial ways, how much of their assets are expropriated through capital gains taxes on paper increments related to inflation? How do such losses in real wealth interfere with life styles they have earned? This, discussed more fully later, and the comparable paper increment problem which may be faced by an older farmer or other small business operator, illustrates how tax policy can impede freedom of choice by those who have succeeded in preparing for retirement.

Many older Americans, but not all, have dreamed of the day when they could leave the pressures of a job at which they had to work to pay family bills whether they like it or not, and could relax doing the things they always wanted to do but could not—education, travel, recreation.

For some in business, professions or other skilled vocations, the dream may have included a hope for a life-style change permitting them to share their practical knowledge with the young. For some, who worked as a sedentary occupation, it may have been a desire to use their hands, with or without pay. For some in manual work, such as the autoworker facing the assembly line's monotony, it may have been a chance for mental activities or opportunities offering a wide variety of experiences.

How well are we meeting the needs associated with desires for such life-style changes? How does government policy at all levels encourage or impede fulfillment of such dreams? How fully is the private sector, business, labor, et cetera, opening or closing doors to personal fulfillment in later years?

Still other older Americans have given clear expression to their dream that they be permitted to continue their chosen vocations as

long as and to the extent that their personal abilities permit. Hundreds of thousands successfully pursue this choice in later life. How many more are there who would like to do so, but are denied the right by corporate decisions, especially in the private sector of society?

How can policies and individual actions related to age best permit full expression of such varied dreams?

ESSENTIAL TO ADEQUATE NATIONAL RESPONSE TO THIS KEY QUESTION IS A NEW LOOK AT RETIREMENT AS SUCH AND WHAT IT MAY OR SHOULD MEAN TO SATISFYING LIFE-ROLES FOR OLDER AMERICANS.

TIMING AND CHARACTER OF RETIREMENT

A most obvious question for both society and the individual is: "When should a person retire?"

Neither public nor private leadership has given adequate attention to this question or current research findings on it. Instead society has denied the individual a choice through blind adherence to 19th century concepts of aging.

It is well known that Germany's Bismarck selected age 65 as the retirement age for his social programs a century ago because in his day so few people reached that age. What does our scientific community, as represented by both physical and social scientists, think of its validity today?

Is 65 too high or too low an age for division between "young" and "old"? In view of diversity among individuals, can any age properly be designated as a dividing line?

Does it make sense to force the professor into full retirement at 65 or 70, when he may then be at the height of his teaching powers? Is it reasonable to expect the steelworker who has been facing a blast furnace since he was 18 to wait until he is 60 or 70 before leaving its heat? Are different retirement provisions desirable for American Indians who have a life expectancy of little more than 40 years, or for members of the Mexican-American community for whom the age 60 may, as indicated in Committee on Aging hearings, be far advanced? How shall we approach special problems of other minorities, including the important 10 percent of our population who are black and have faced deprivation throughout their lives?

Related to these questions as they may affect individuals or special groups are the broadgaged social and economic implications of current trends toward earlier and earlier retirement.

Are practices which tend to place persons "totally in" or "totally out of" the work force, by reason of age, in the best interest of older persons? Of employers? Of the Nation as a whole? Or should there be a conscious effort to provide opportunities for flexibility in retirement and employment practices aimed at gradualism in work-force withdrawal and greater individual choice?

Some gerontologists suggest that lengthening life and expanding living capacities during later years call for delay in age of retirement. Some suggest policies by employers which will permit and encourage a gradual phasing out in employment through such devices as periodic

reductions in days or hours of work, use of longer vacation periods and sabbatical leaves in middle and later years.

How do these ideas relate to recent experience which has seen average retirement age falling steadily?

Since probable income required to satisfy normal desires may be higher when an individual retires early, how does the trend toward earlier retirement affect ability of older persons to pay their bills? How far can the Nation go in expecting the producers in society to carry the load for nonproducers? To the extent that producers may be caught in the squeeze created by simultaneous later and later entrance into the work force by the young on one side and earlier and earlier departure from it by the old on the other, what may be the workers' reactions as new demands are placed on them?

Will their own hopes and expectations of early retirement make the young and middle-aged worker willing to pay the bill? Or is there risk that continuation of retirement trends may so overburden retirement funds as to threaten decent living standards for the old as a whole? What may be the affect on those who need help most? Is the claim sound that the Nation can easily support a policy of earlier retirement because of increasing production, or will the old still be denied their fair share because of heightened personal demands by their juniors?

It goes without saying that rising levels of education and health stimulate interests and appetites among older Americans which will not be satisfied with yesteryears' simple standards of food, clothing, and shelter. This is evident among today's elders. Progress in living standards has both increased their numbers and strengthened their capacities in comparison with their grandfathers. It has brought them a zest for living rarely satisfied by three meals a day and a comfortable rocking chair. How do the implications of this continuing revolution in aging relate to retirement patterns in America?

Implications of Increased Leisure Time

The question of increased leisure time resulting from greater use of labor-saving devices and techniques and prospects for further automation has long been a serious concern to social scientists. How can both young and old be made aware of life-long implications of this issue to them as individuals and to society?

How shall increased leisure time be apportioned? Shall it be concentrated mainly during the later years through earlier and earlier retirement? Should leisure time, instead, be spread more evenly throughout a life-time by emphasizing shorter hours and shorter work weeks?

What are the social responsibilities of business and labor in strengthening individual choices in use of leisure time? Are their decisions, which dominate national practices, being made with full understanding of long-range changing patterns of aging as seen by economists, sociologists, gerontologists, and other experts?

Whatever decisions are made on use of leisure, it will continue as a major factor in lives of older Americans. Their needs will require increasingly effective responses by society.

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Leisure without income sufficient for its joyful use is a hollow sham. Leisure without ready availability of services can be negative even when income appears adequate. How can society meet its responsibilities toward assuring retirees opportunity for the golden years?

When will we give proper priorities to development of service programs to strengthen retirement activities for all older persons?

How should such responses acknowledge unique problems faced by minority groups? How can they be modified to accommodate differences in community settings—urban, suburban, rural?

The recently expanded hot meals program is one example of the kinds of programs to which such questions might appropriately be applied. This program has clearly demonstrated its value for many older persons both nutritionally and socially. Another example is offered by senior citizen centers sprinkled throughout the land. In the inevitable competition for limited tax dollars, how far can government, Federal, State and local, go in providing for such activities? Is there an untapped capacity for meeting such needs within the private sector? If so, how can it be activated?

Adequacy of response to needs in housing, medical care, social services and other essentials to acceptable living standards—discussed elsewhere in the Special Committee on Aging report and in previous minority reports of the committee—are obviously of consequence to the status of older Americans. Equally obvious is the fact that so far the record in these areas has been spotty.

How can the young and middle-aged, business, labor and government, be made fully aware of the transportation problems faced by the old, and their relationships to life quality? How can America solve them?

This "sleeper" problem, brought out by the 1971 White House Conference on Aging, because of its almost universal impact deserves special re-emphasis at this time.

As the Nation grapples with transportation needs for all, can we hope that unaccustomed problems faced by the young because of energy shortages will give them a new understanding of the kinds of privations long suffered by hundreds of thousands, perhaps millions, of older Americans?

Isolation and loneliness, the terrifying twins that can threaten the elderly are perhaps the most negative element in aging. They are realities far too often for far too many older persons, and are commonly a direct product of inadequacies in transportation. To them must be added difficulties faced by the elderly even in such simple chores as getting to the grocery, drug store, or to the doctor.

How can Americans meet the critical need for dependable, economical transportation? What are the full dimensions of the problem? How does the problem vary in different types of communities—inner city, rural, suburban? To what extent can the issue of transportation for the elderly be divorced from unmet transportation needs of the total population? Can special transportation services for the elderly be effective without more adequate public transportation facilities for all?

Our brevity in raising these questions on transportation does not minimize their importance. On the contrary, the complexity of the problem almost staggers the imagination. But few issues are more important in helping the aged attain even the simplest satisfactions in life.

Variables Within the Older Population

How important are differences in age, sex, social circumstances and geographic location within the over 65 population?

How much do such needs among the retired population differ by reason of age? Is or is not a more vigorous type of activity needed by those below age 75 or 80 than among the most elderly? How does the ability to meet their own needs differ among older persons of various ages? How do such age differentials apply among minority groups? What are implications of such questions for the design of services?

More than 60 percent of those past 65 are under 75; 20 percent are over 80; 8 percent are over 85. Disregarding individual variations are there any general patterns which distinguish such age groups? Are there differences in aspirations, appetites, needs, abilities or sense of responsibility? Do census and other reported data give us accurate clues relating to who, what and where they are, or is statistical grouping too imprecise?

Are there differences between older men and older women in achievement of satisfying social and economic roles for each? How are these influenced by their respective patterns of life prior to 65? If so, are changing work patterns by women narrowing or broadening such differences?

How do differences in family status affect the aspirations, needs, and social or economic roles of older Americans? To what extent, if any, do we discriminate in aging policies for or against married couples, single persons, widows and widowers?

In their concern for satisfying roles in society and individual sense of worth, persons past 65 appear little different from their younger fellow-citizens. As has been observed earlier, for those who retire it may be that the emphasis is shifted from work-a-day job to voluntary service or service within their own families. It may be that retirement is used as a base for second careers, or appropriate modifications of life-long pressures. It may be that retirement is used for personally satisfying leisure and learning activities denied in youth or for personal growth unrelated to a job.

To what extent, in the various possible groupings of the 21 million persons past 65—does a sense of worth and happiness depend on service to others?

How can individuals who strongly feel this need be helped through opportunities for non-paid volunteer services such as those which have had increased Federal emphasis in recent years? To what extent is it practical for willing older persons with limited economic resources to participate? Is it necessary to expand earnings opportunities as part of volunteer programs?

To what extent does opportunity for continued productive activities, with or without pay, influence the health of older persons? How

can this balance against costs of such programs? Again, are there differences in this regard related to age, sex or ethnic factors among persons past 65? How do they interrelate to such other influences as personal income and education levels?

How important to older Americans are opportunities for jobs, full time or part time?

At best the answers to this question are not clear. It is apparent, however, that the vast majority of persons past 65 strongly resent business customs and government actions which limit their rights to jobs. This resentment of second class citizenship is voiced by persons over 65 who are fully retired, persons who are out of work only because of compulsory retirement and persons who are actually working full time or part time.

Our purpose here is to re-raise broad questions to which national leadership, private and public, should give priority in decisions related to older persons in a changing world.

To the extent that efforts have been made—by Congress, by White House Conferences, by labor leaders, by business, by organizations of older persons—to develop answers, there has always been a risk of oversimplification. In the days ahead we believe it imperative that policymakers give new emphasis to the complex pattern of life among today's 21 million *persons* over 65 and those who will take their places in the future.

When we talk about policies in aging, we give concern to hundreds of millions of Americans including those now in their infancy. If society continues to ignore the wide variations in hopes, aspirations and unmet needs among those who are now old, it denies them their valid rights as Americans to life, liberty and the pursuit of happiness. If society ignores the individuality of those who will become old tomorrow, it no less denies their rights to personal versions of the American dream.

Inherent in our questions on roles in aging is our long-time insistence as members of the Senate Special Committee on Aging that older Americans are entitled to first class citizenship with maximal individual choice. We raise these questions, some of which will be re-emphasized below because of our growing concern about our Nation's persistence in outmoded concepts of age and older persons.

PRIVATE SECTOR AND GOVERNMENT RESPONSIBILITIES

II. *How can America's private sector and government at various levels fulfill their several responsibilities for expanding freedom of choice by older Americans in society's economic and social life?*

The wording of this question rejects the idea, voiced too often, that there are specific areas of responsibility in aging which should be assigned exclusively to any of America's social institutions—be they Federal, State or local government agencies or labor unions, professional societies, business corporations, or other private agencies. Few if any of the thousands of impediments to free choice by older Americans can be successfully attacked through simplistic ap-

proaches or allocations. The people and their needs are pluralistic; so too must be responses to them.

America's approach to needs of older persons calls for effective partnership of all its great social forces using the strengths of each even as we avoid their weaknesses.

Transportation

Transportation needs of older Americans, to which emphasis was given in the previous section of these views affords a good example.

Is the transportation problem one which can be met only through massive Federal expenditures? Or should Federal emphasis be given to creation of a climate in which the resources of private enterprise can be stimulated to meet the problem? Or should there be a combination? How does experience with the postal service, which sees profit-oriented companies successfully competing for its business, relate to these questions?

How do alternative solutions to the unique transportation problems of the cities and the rural areas, where public transportation is sometimes nonexistent, relate to basic financial problems local communities face? Is Federal or State subsidy needed? If so, to what extent and in what form? Can such subsidies be devised so as to give equitable treatment to all citizens regardless of residential circumstance? If not, whose needs should receive greatest or first attention?

To what extent have Federal, State, or local regulatory agencies stimulated or stifled development of public transportation?

The transportation problem, as observed previously, deserves special emphasis now because of the possibility that recent developments may bring to the young and middle-aged a new understanding of long-time problems faced by the elderly. Some of the special characteristics of this problem in aging are discussed at length elsewhere in this Special Committee on Aging report. We concur in the importance of seeing that new responses to the problem give full consideration to these needs.

Elsewhere in this committee report there appear detailed discussions of many other problems faced by older Americans. We agree emphatically that there should be prompt action to meet them. Action which fails to respond to the kinds of broad questions we are now raising, however, invites continued short-fall or misdirection in problem responses.

Inflation

Before pursuing the complicated questions about interrelated private and public responsibilities for adequate incomes among older Americans, it is appropriate that we reaffirm our serious concern about rising costs of living.

THE MOST SERIOUS PROBLEMS OF TODAY'S OLDER AMERICANS ARE THOSE GENERATED BY THE CONTINUING INFLATION SPIRAL. As repeatedly observed in previous Special Committee on Aging minority reports over the years, inflation is the No. 1 Public Enemy of older America. NO ONE NEEDS TO BE TOLD THAT FOR MANY THE PROBLEM IS REACHING CRISIS LEVELS.

That inflation rates have been lower in this country than elsewhere is small comfort. That much of the recent inflation acceleration has sprung from factors beyond our own control, such as the petroleum shortage, in no way reduces need for positive action by America. Control of rising living costs demands highest national priority.

We have noted in the past that unnecessary Federal expenditures and costly involvement in foreign wars contribute seriously to erosion of the dollar's purchasing power. We shudder at the thought of inflation problems which would now prevail if we were still involved in the Viet Nam War.

Essential as reduction in ill-considered, unjustified and wasteful Federal expenditures are, however, it is apparent that sound fiscal policies alone are not enough. In the face of sharply increased worldwide demand for goods and services, meeting the challenge of inflation also calls for increased productivity by America. Perhaps one source of increased productivity may be wider use of older Americans who want to continue work, full time or part time. Unquestionably, full cooperative effort by all elements of society, public and private, is needed to control the complex factors which fan the fires of inflation.

SSI: Supplemental Security Income

Even without the universal reductions in older Americans' purchasing power to which they have been seriously subjected since 1965, there are many elderly whose incomes have always been inadequate for even the barest necessities of life. There are others for whom minimum subsistance may be available, but who lack simple comforts and amenities of life to which they should be entitled.

The recently inaugurated Supplemental Security Income (SSI) program establishing a new Federal income floor for persons past 65 is a giant stride to help those with lowest incomes. Although improvements are needed to meet the goals as originally envisioned by the administration and Congress, SSI reflects new national recognition of one major responsibility of the Federal Government.

New as SSI is, several questions about its performance and future deserve early answers. Is the SSI income floor adequate? How many people are benefiting? How many are receiving supplements which give them only the *minimum* SSI income standard? What is the numeric distribution at various levels for those who qualify for *more than the minimum* because of "disregarded income," such as $20 of Social Security benefits and part of earned income? How clear is the understanding of such "disregards" among potential SSI beneficiaries? How many of the people expected to benefit have failed to qualify? Are all who are entitled to SSI aware of its availability to them?

Without answers Congress and the administration will be unable to make modifications required if SSI's response to income needs is to be fully effective.

Government acceptance of responsibility for basic minimum incomes through SSI, and individual State supplements to it, is only

part of the picture. Society has an income responsibility to older Americans which goes far beyond acceptable subsistence standards.

Effective combination of private initiatives and Government programs are necessary if we are to attain our goal of incomes that offer older Americans fullness of opportunity in vigorous pursuit of personal objectives.

How shall an appropriate mix of public and private income programs and other income sources, including earnings and individual savings, be developed to achieve this purpose with fairness to all? This question deserves thoughtful re-examination by all segments of society with recognition of the special genius each may offer in meeting the need.

OASDI Under Social Security

Any appraisal of income adequacy must include questions about the old-age, survivors and disability insurance (OASDI) provisions of the Social Security Act. Since roughly two-thirds of the current elderly now receive benefits and 90 percent of the younger population is covered under OASDI, it is a national imperative that there be constant reassessment of its performance and ways to improve it.

Questions about OASDI which follow—including those about its interrelationships to other economic factors in American life—are among those which we felt should be given continuing full-time review by an independent bipartisan Social Security Commission when we recommended its creation in our minority report 2 years ago.

We believe that Social Security, as the Nation's biggest and most pervasive income program, deserves no less than constant scrutiny and overview by a competent agency independent of its administration.

As we said 2 years ago, nothing in our recommendation implied criticism of the program's mechanical operation under the Social Security Administration. To the contrary, we believed that the Social Security Administration, under both Republican and Democratic Presidents, had been a model of efficient and fair performance. We did raise a major question, however, as to the propriety of leaving in the hands of the administering agency the evaluation of its economic effectiveness or of relying so heavily on it for policy recommendations. We believe this question is still valid, perhaps more than ever.

Our recommendation for an independent bipartisan Social Security Commission, which was given legislative form through Senator Fong's introduction of S.J. Res. 48, included clear intent that the commission be responsive to and of assistance to the Senate and House of Representatives and that a part of its membership be named by congressional leadership.

The first question regarding OASDI, as distinct from Medicare and SSI, is suggested by recent observations of some professionals in the economics of aging. They raise the question because of major benefit increases, including automatic living cost adjustments, during the past 4 years simultaneous with development of the new SSI program.

Has OASDI reached or approached its zenith as an instrument in providing retirement income to older Americans? If so, to what alternative mechanisms should the nation turn to assure adequate incomes

in old age? If not, what reasonable ceiling should apply in its expansion and what emphasis should be given in further growth?

All other questions impinge on how the Nation answers this fundamental question about OASDI's ultimate magnitude. The answer will reflect public opinion regarding retirement income responsibilities of government, private financing systems and individual savings. It will have serious impact on America's entire economic system.

If there is to be further OASDI expansion, to what purposes should the necessary additional taxes be directed? Should they be used for across-the-board increases? For correction of inequities in the tax-benefits relationship—such as those experienced by working couples, persons who continue work after 65, and unmarried individuals? For increases in the number of retirees through lowering the eligibility ages for benefits? For higher benefits to those whose earned incomes have risen steadily throughout life by calculating benefits on the highest 3 or 5 years of covered earnings? For increased minimum benefits to persons with long attachment to the work force at lowest wages?

How far can the Federal Government go in raising taxes necessary to an expanded OASDI? In a very real sense this might be described as the "$64 billion" question. Are complaints received by Members of Congress about Social Security tax increases simply a concern by a small percentage of taxpayers, or do they reflect widespread discontent? How does this relate to evaluations of future changes in OASDI?

For the most part young and middle-aged citizens apparently have gladly accepted tax burdens necessary to provision of current OASDI retirement benefits. For this they deserve commendation. But economists agree that, no matter how well motivated toward their elders the young are, their willingness to accept responsibility for retirement income to others largely depends on confidence that they in turn will receive comparable benefits when they themselves become old. This emphasizes the importance to today's older Americans of assurance to their juniors that current and future financing of OASDI, or any other pension system, be economically sound. The many persons who have inquired about OASDI's financial status should, therefore, not be ignored.

How sound is the Social Security system? While we have confidence in it, the American people deserve—and Congress needs—valid answers to all questions related to financial integrity of OASDI.

Much has been made of the trust fund generated by Social Security taxes. Some have felt the OASDI trust fund constantly should hold an accumulation of assets adequate to pay all future claims in the same way as private plans must do. This view is not shared by the experts. The political economist regards OASDI as a "transfer" arrangement which requires only that there be assurance that (1) current tax receipts are sufficient to pay current benefits and meet limited unexpected contingencies, and (2) future tax receipts will be able to pay for future benefits. The integrity of OASDI therefore depends on the validity of actuarial assumptions regarding income and outgo.

Are current OASDI actuarial assumptions and financing appropriate to its long-term requirements? This question is appropriate because of changes in actuarial assumptions and financing which were accepted by Congress in 1972 when it enacted a 20 percent benefit increase without comparable tax increases. Sharp criticisms of this change by some economists and actuaries have generated debate which we believe has received too little attention. We acknowledge our own need for further information about conflicting expert opinion on this question before we can feel free to support major changes in a system which now serves the people so well.

A distinguished expert on Social Security, former Secretary of Health, Education, and Welfare Wilbur J. Cohen, in testimony before the Special Committee on Aging, minimized importance of these changes in actuarial assumptions and financing with these words:[1]

> That is not to say that there are not bona fide criticisms of the present program, but on the whole these do not go to the fundamental aspects of the program by any substantial sector of the Nation. Although some economists have made a number of criticisms of the financing of the program, these views are not so widely shared by the beneficiaries or taxpayers.

With all due respect to this opinion, we question such easy dismissal of questions which could have serious implications for a program as essential to future retirees as it is to current beneficiaries.

Absence of concern by *beneficiaries* or *taxpayers* may only reflect understandable ignorance of the questions—ignorance resulting from lack of publicity about them. Nor should it be overlooked that employer taxes become an added cost to them for doing business and are reflected in their prices.

We believe it is legitimate to ask how well Congress itself understands this issue. We believe at a minimum there should be full examination of the basis for the differing expert opinions. Such exploration by this committee and others in Congress sharing our belief in the importance of a sound OASDI appears an appropriate ingredient in legislation of the future. Even if such review should show the debate to be a tempest in a teapot we believe an informed judgment by the public and Congress is desirable.

Are major changes in OASDI financing desirable? Most particularly, should the Social Security tax on wages be replaced totally or in part by financing through general revenues? Proposals for such a change have been advanced on numerous occasions during recent years usually on the grounds that the wage-tax is more regressive than income and other Federal taxes and thus penalizes workers with lower incomes. Social Security Administration officials, on the other hand, have pointed to the advantages given low wage earners in the OASDI benefit structure as an alternative method for giving preference to them. Is this existing advantage for the low-paid participant when he becomes a beneficiary more important than reduction of his taxes while he is working? Or is the latter more imporant? Is there some way that both purposes can be achieved? Is there risk in use of gen-

[1] Testimony by the Honorable Wilbur J. Cohen on "Future Directions in Social Security", hearing before the Special Committee on Aging, U.S. Senate, Washington, D.C., July 25, 1973.

eral revenue financing that benefits will lose status as an earned right? Would this be acceptable to either young or old?

The American Association of Retired Persons, the National Council of Senior Citizens, the National Retired Teachers Association, have expressed the view that it is important to retain the relationship of benefits to earnings and the contributory principle which use of the Social Security tax on wages emphasizes. On the other hand they share our concern for workers whose Social Security taxes often exceed their Federal income tax liability. Some believe that only through the wage tax can the taxpayer understand how much of his income is going to support of OASDI beneficiaries. How much weight should be given to each of these and other views about financing methods?

Other Federal Income Programs

Important as OASDI is, it does not stand alone as the source of retirement income. In our quest for adequate living standards for older Americans, attention must also be directed to income potentials in other government programs, private pension plans, individual savings and other resources.

Currently OASDI has over 19 million beneficiaries aged 65 and over and almost 3 million aged 62 through 64. Other Federal programs providing income are numerically distributed as follows:

Railroad retirement: 448,000 retirees; 210,000 wives; 290,000 widows.

Civil Service retirement: 921,600 retirees; 359,600 survivors.

Veterans pensions: 1,028,000 veterans, 690,000 widows.

Military retirees: 1,000,000.

Supplemental Security Income (SSI): 3,200,000 aged, blind and disabled.

A precise determination of how much income these programs provide to older Americans is extremely difficult because age-related data is unavailable for many of their recipients.

In understanding the multiple effect of the Federal programs it is necessary to answer several questions about their interrelationships. What are benefit levels resulting from payments to individuals by more than one of these programs? How do changes in benefits under one program affect payments under another (i.e., reductions in veterans pensions because of OASDI increases)? Is restructuring of any of these programs desirable in the interest of integration or equity? In view of differing purposes for the several programs, is such restructuring feasible (i.e., military retirement may be regarded as an alternative to higher pay during active service; the service also retains a right to recall "retirees" to active duty)?

The largest governmental retirement system outside of Social Security is the Civil Service program. Questions about its possible coordination with OASDI indicate problems in integration of the various Federal programs, or even understanding of how they relate to each other in providing individual incomes.

How many persons now in retirement receive payments from both Civil Service and OASDI? Is the percentage of such duplication likely to increase or decrease in the future? How many persons currently working have coverage under both systems? How much movement is there between Government and non-Government jobs by current employees? Between State or local government and Federal employment? To what extent do persons making changes gain or lose benefits? How important are such questions in a mobile employment society in terms of both geographic and nongeographic moves?

Should Federal employees be required to participate in OASDI? Should Federal employees, instead, have opportunity to interchange credits under OASDI and Civil Service? In this connection is the Civil Service retirement system, which antedated Social Security by many years, more comparable in purpose to private pension plans or State government retirement plans than it is to OASDI?

How do questions of this kind apply to the railroad retirement program in future efforts to make it better serve its beneficiaries? To the retirement benefits offered by the Armed Services?

Private Pensions and Individual Savings

To what extent do private pension plans help the aging in their quest for economic and social independence? How important will and should such plans be as sources of income in the future? Are they sufficiently flexible?

Private pension plans for large employee groups as of January 1973, covered 33,235,000 active workers according to the Life Insurance Institute, and were making benefit payments to 5,660.000 retirees. Payments made during 1972 amounted to $43.8 billion. Plan growth during the most recent 10 years is shown by comparison of this figure with payment in 1962 of only $14.7 billion. In this connection it is noteworthy that major growth in private plans came largely after conclusion of World War II.

Prior to 1963, private retirement programs were limited largely to employees of good-sized business firms. Adoption that year of the Keogh Act, and subsequent improvements in it, has extended the private pension system to farmers, professionals, small business operators, and other self-employed persons. Requirements for coverage of employees of such principals has been important.

Because of the multitude of financial institutions offering plans which qualify under the Keogh Act—insurance companies, banks, mutual funds, and others—there apparently are no clear data as to the number of persons now participating in such plans, either as current contributors or beneficiaries. The number of persons and dollars involved is presumably substantial. Until more facts are known, however, estimates of private sector responses to retirement income needs will be incomplete.

The overall performance of private pension plans offers an outstanding example of America's imaginative free enterprise system in action despite occasional instances of nonpayment due to failures of sponsoring business firms (reportedly affecting less than $\frac{1}{10}$ of 1 per-

cent) and inadequate safeguards of benefits for workers who leave a job prior to retirement.

Imminent final approval of vesting provisions and financial safeguards in H.R. 2, the Employee Benefit Security Act, should reinforce growth of the private pension system as a mechanism for individual economic security. Even as the bill is being enacted, however, it is being challenged on grounds that it offers inadequate protection to the individual whose union membership or work period with a particular employer is of relatively short duration. If these charges are valid, do not plan sponsors have a self-interest in voluntary moves toward correction?

Pioneered in this country on a base of vigorous leadership by labor unions, business enterprises, the life insurance industry and other financial institutions, the private pension approach has been given increasing recognition elsewhere in the world as an important ingredient in efficient provision of retirement income. France, Japan and other countries have followed America's lead in developing private systems to supplement government programs.

Will America's private sector continue its leadership? Will future developments in private pensions emphasize broad long-range social responsibilities; or will they be geared to narrow short-range interests of plan sponsors? Will private pension plan design reinforce social and economic pressures that restrict personal freedom of action solely because of chronological age? Or will it give recognition to the individuality of Americans and their right to choices? Is there any element in the private sector, including financial institutions which sell plans, whose self-interest permits it to ignore such questions?

If the past has taught any lesson, it may be that attainment of any fully satisfactory response to individual retirement income needs is unlikely if reliance is placed on any single system. Even with 100 percent coverage, it is almost inevitable that many persons will face inequities against which they must protect themselves. This raises a serious question of importance to millions of our Nation's citizens.

How can personal initiative opportunities for retirement income be increased, so that persons missed by private pension plans—or inadequately served by the government-private complex—can achieve decent living incomes for their senior years? This question deserves most serious consideration by Congress in its efforts to strengthen legislative responses to needs of older Americans.

The major Federal contribution to the development of private pension plans, both large and small, has been the preferential tax treatment it has given to them. Desirable and essential as these tax concessions are, *is it not legitimate now, to ask why comparable consideration should not be given under tax laws to individuals in their strictly personal efforts to prepare for retirement?*

Without changes in tax treatment of *individual savings for retirement* vis-a-vis *savings through "qualified" programs*, the Nation discriminates against the individual who is either omitted from the latter or inadequately served by them.

Tax incentives for such individual efforts by persons *not covered* by group plans is offered under H.R. 2, with annual contribution

limits of $1,500. Is it unreasonable to make similar incentives available to persons who are *covered inadequately?*

Earlier in this statement we referred to losses in real wealth by older Americans—through capital gains taxes on sales of homes or small business—and consequent reduction of *earned* capacities for meeting their own financial needs: Cannot this Government afford to remove this kind of tax impediment to economic independence in later life?

As we raise this question, we are fully aware of the special, but limited, capital gains tax treatment which has been given since 1964 to persons over 65 who sell their homes. When the late Senator Everett McKinley Dirksen first introduced that proposal, his original version called for complete exemption of such gains after 60. Would it not be appropriate now to consider full acceptance of the original Dirksen proposal?

Would not similar tax treatment of other capital accumulations, at least to the extent that they simply reflect inflation-created paper profits, also be worthy of consideration? We raise the question with full consciousness of the complex elements involved in the tax law. Possible impact of changes could be substantial. It would be imprudent therefore for us now to urge comprehensive specific changes. WE BELIEVE, HOWEVER, THAT THERE SHOULD BE A CAREFUL REVIEW OF ALL TAX PROVISIONS WITH SPECIAL CONCERN FOR POSSIBLE WAYS IN WHICH THEY PREVENT OR IMPAIR PERSONAL INITIATIVES AT ANY AGE TO ACHIEVE INDEPENDENCE IN RETIREMENT.

COMPULSORY RETIREMENT AND EMPLOYMENT

In the section of this statement devoted to satisfying life-roles for the aging, we have raised questions about the importance to many older persons of employment, part time or full time. *We now raise additional equally serious questions about broad national retirement policies and trends which deserve comprehensive review, with full use of current studies, by government and by the private sector.*

Expert analyses of the "aging problem" have repeatedly advanced the argument that the best interests of older persons and the Nation call for greater flexibility in retirement practices. Apart from possible health, social, and economic advantages for older Americans which it might bring, would flexibility have a favorable or unfavorable impact for the Nation through its effect on production of wealth or on tax burdens? How much would it help or hurt younger workers and business enterprises?

The evidence received by this committee strongly reinforces the view that flexible retirement policies will benefit all Americans. If this view is not correct, is it not time for effective presentation of contrary evidence?

IF IT IS SOCIALLY AND ECONOMICALLY DESIRABLE THAT OLDER AMERICANS HAVE MORE CHOICES IN THEIR RIGHT TO BE PRODUCTIVE, THE LARGEST RESPONSIBILITY FOR DEVELOPING SUCH FREEDOM RESTS WITH THE PRIVATE SECTOR BECAUSE IT DOMINATES THE EMPLOYMENT MARKET.

Corporate interest in advantages to be derived from flexibility in retirement rules should not be ignored. There is no evidence that employer self-interest conflicts with socioeconomic values and morality associated with first class citizenship for older Americans.

Unless and until society collectively is willing to assume the cost of providing the elderly with all the income they feel they need as individuals, is it right to deny the aging the opportunity to meet those needs through self effort?

Since the alternative to earned income may be public largesse, can private employers afford to deny jobs to older persons? Does not self-interest as well as social conscience require instead that the private sector offer *leadership* in expanding job opportunities?

If it is accepted that job opportunities can be important to many persons past 65, how can the Nation best eliminate present barriers to such choice? How far should it go in such efforts? *How fully do potential employers, large and small, understand the positive benefits they may gain from giving jobs to able, willing older persons?*

What are the impediments to employment of older workers, even as early as age 40, that employers confront because of law or general customs? How free are employers to modify current practices in the face of competition with other employers in the labor market?

One of the most frequently cited obstacles to unilateral job opportunity expansion by employers is related to their pension plans and "excessive costs to them" when they hire older workers. How valid is this claim? To the extent that it is valid, how can changes be made which will resolve the problem as it affects both employer and would-be employee? In resolution of the problem what is the responsibility of vendors of pension plans, such as life insurance companies?

Another problem faced by employers in hiring older workers, at least in some lines of business, is alleged to be insurance costs, including liability. To what extent does this problem exist? To the extent that it does, how valid are insurance cost differentials in the light of work and safety experience among older employees?

Employers most legitimately have to consider costs when an employee is hired. Is there now adequate information on such costs in different occupations? Are there ways such costs can be met or minimized? If knowledge is inadequate, how can it be developed? If sufficient facts exist, how can they be brought to the attention of decision-makers within the labor market?

Dominant as attitudes within the private sector of society may be in determining national retirement policies, it is obvious that Federal programs are important. How enlightened are they? To what extent do Federal programs work at cross purposes?

Federal law prohibits job discrimination against persons between the ages of 40 and 65. Does the exclusion of persons over 65 from this protection give sanction of law to the view that discrimination after 65 solely by reason of age is acceptable? Does this violate basic rights of citizenship among the aging?

Substantial authorizations of Federal funds have been made by Congress to create job opportunities for older Americans. How consistent

with this purpose are impediments and disincentives to work which are found in other programs such as OASDI under Social Security?

Many older Americans, as noted previously, eagerly accept retirement from the work force as an opportunity for life-style changes which they fully expect to enjoy. Many others, on the other hand retire only because they are forced to do so and are unable to find suitable new jobs, either part time or full time. Some persons forced into retirement are understandably reluctant to seek out jobs, especially full time, when the "special tax" imposed through work penalties under Social Security is added to regular income taxes and other job costs so as to leave them little of what they might earn. There are still other persons past 65 who have elected to continue full time work, despite the penalties they suffer.

How many more would there be if the penalties were removed? How many more would work beyond age 65 if retirement rules were modified by employers? There are also many who work part time after 65. *How many of these limit their hours solely because of Social Security benefit deductions?*

In consideration of future amendments to the Social Security Act, how much attention should Congress give to the effect of OASDI provisions on employment of older persons able and willing to work? To what extent should needs of the latter be balanced against increased benefits for the fully retired?

If current employment disincentives in the Social Security system are wrong, how can their modification best be achieved? Should earnings limitations be completely removed in the face of admitted high cost to the Social Security system? Should amendments to the work test be approached on a gradualistic basis such as through provision of increments in benefits to those who defer retirement past 65, or through gradual raising of the earnings limit, or a combination?

A bill, S. 3386, to provide a 6⅔ percent annual increase in OASDI benefits for persons who defer retirement to ages beyond 65 has been introduced by Senator Fong on behalf of all Republican Members of the Special Committee on Aging (Senators Fong, Hansen, Gurney, Brooke, Percy, Stafford, Beall, Domenici, Brock), Committee Chairman Frank Church, Subcommittee on Employment and Retirement Incomes Chairman Jennings Randolph and others including: Senators Wallace F. Bennett, Marlow W. Cook, Alan Cranston, Robert Dole, James O. Eastland, Paul J. Fannin, Philip A. Hart, Floyd K. Haskell, Daniel K. Inouye, James A. McClure, Gale W. McGee, Frank Moss, Abraham Ribicoff, William V. Roth, Jr., Strom Thurmond, and John Tower. This bill is a slight modification of a similar proposal introduced last year as S. 2815 by Senator Fong with cosponsorship by Senator John Tower.

At the time of the bill's introduction, it was pointed out that the annual increment it provides is identical with percentage reduction in benefits which applies under the present law when persons take early retirement. As such it would implement at least partially the recommendation for greater flexibility in OASDI advocated repeatedly by minority members of the committee in previous reports.

If earnings test liberalization is a proper route to follow, as we also believe, should such process be left to individual actions by succeeding Congresses, or should a planned phaseout extending over a period of years be considered at one time? A precedent for the latter approach is provided by congressional action on Social Security taxes which defer their impact on workers until years ahead. If appropriate in one case, is it less appropriate in the other?

The whole question of the earnings test under OASDI raises other questions. There is conflicting evidence, which needs to be resolved, on such matters as (a) ultimate actual cost of such a proposal to the Federal Government and taxpayer, (b) the extent to which it would encourage continuation within the work force of persons past 65, (c) the extent to which it would help older workers between 40 and 65, (d) the effect it would have on jobs for younger workers, (e) its ultimate cost or gain for employers, (f) its comparative impact on older persons who are economically deprived and those who are affluent, and (g) its relationship to benefit increases for nonworking older persons.

It is apparent that any cost to the Federal Government of elimination of the earnings test, for example, depends on factors other than the immediate direct cost to the Social Security system alone. If the test elimination increases employment among older Americans, how much additional Federal revenue would come from income taxes and Social Security taxes such workers would pay? How much would tax burdens on Federal, State, and local programs for indigent and medically indigent older persons, including SSI and State supplements to it, be reduced? How much would the Nation benefit economically through additional wealth produced by older workers? What would be the effect of increased production of goods and services on inflation?

What Strategy?—Services or Income?

There has been a prolonged debate related to the Government "strategy" in meeting needs of older Americans. *Which strategy should Government pursue: "income" or "services"?*

Those who argue for a services strategy have acknowledged, of course, that income is essential. They have maintained, however, that there has been inadequate attention by Government to development of services for the elderly.

Those who advocate an income strategy have acknowledged the importance of services to the elderly, but maintain that, given the necessary dollars to pay for services, such services can be bought in the way selected by the individual.

Even as they defend their special positions, advocates of either strategy would probably acknowledge that this division oversimplifies the problem. Older Americans do need income; they do need services.

The debate is concerned with *emphasis* in the face of competition for limited funds. How much of the tax dollar should be devoted to

services? Since varied needs among the elderly call for a host of differing kinds of services, what kinds should be given highest priorities?

Who are the aged in need of services? They include members of minorities whose senior years often involve extensions of discrimination and deprivation they faced throughout life. They include persons of all ethnic backgrounds who are not only poor, but live in communities where life qualities are limited regardless of income. They include the isolated in rural areas for whom transportation necessary to social intercourse and acquisition of services is sharply limited. They include the lonely, whose families and neighbors have departed from them. They include the poorly housed, the sick, the feeble, the fragile and the fearful. *Important as income would be to these programs, is it enough?*

They also include vigorous, active persons who are denied opportunity for self-expression and social communion with their peers because facilities and services related to them are unavailable in the community. What is Government's responsibility to them apart from income?

How much of the Federal services dollar should go for instance to social support vis-a-vis medical care and housing? How far can different types of services be separated from each other? How necessary is their coordination? Are there risks in either segregation or coordination? How does fragmentation bring inefficiencies?

How extensively, for example, should tax dollars be used for senior citizen centers whose primary purpose is to offer opportunity to the elderly for social communion and recreation regardless of income? What kinds of special services can be made a part of such centers so as to strengthen their ability to meet their original purpose? Does a center gain or lose through addition of the federally supported hot meal program? A medical clinic? An employment service? Is this a matter which can be properly determined by persons outside the community in which the center is located?

Among social support services and outreach programs which have been developed on a limited scale across the country are the following: *Information* and *referral* services, offering assistance in obtaining special help from a variety of agencies and acting in an ombudsman capacity to bridge the gap between the elderly and agency bureaucracy; *Meals-on-Wheels* services, for the home-bound; *home aide* services, to help the aged remain in their homes through performance for them of light household tasks; *protective and legal* services; *escort* services, to transport isolated or handicapped elderly to centers, clinics and other service centers; *friendly visitor* and *telephone reassurance* services, to strengthen and reinforce contacts with others in the community; *continuing education* services, and *counseling* services, to help with adjustments to changes in status, employment, deprivation, or with emotional problems which might reduce ability to cope with daily exigencies.

Is it financially possible for the Federal Government to broaden application of these services so as to include all who need them

wherever they live? If so, how much Federal control should be imposed? If not, how can Federal dollars be coordinated with local money to increase their availability?

Assuming further growth in Government sponsorship of supportive services to the elderly, should first attention be given to those with lowest incomes, special ethnic needs, or community problems?

If tax dollars are addressed first to supportive services for the low-income elderly, what responsibilities if any does the private sector, including its profit-oriented agencies, have toward making needed services available to those able to pay? How, if at all, can the efficiencies which private forces claim for themselves be applied to meeting such social needs?

Is it not necessary for Congress and the administration to have at hand a clearer statement of the problems' dimensions as they develop answers to the income-services strategy question? If such pertinent data has been gathered, how can it be fed into the decisionmaking process? If it is not available, how can it be developed?

Better understanding of the "income strategy versus services strategy" in aging is important within the Congress, the executive branch and the public at large. It is not enough that it receive attention from gerontologists, social scientists and other professionals in aging. Limitations as well as values in the question are emphasized through review of its implications in medical care.

Medical Services

Good health for older Americans, in its broad sense, is our ultimate objective in aging. Achievement of a state of well-being, physically, mentally and socially, for the largest possible number of individuals is the goal for which society should strive. Freedom of choice, sense of purpose, fullness of oportunity, adequacy of income, decent living standards and all of the other concerns to which we direct attention are but ingredients in *good health.*

High quality medical care—the art and science of preventing, limiting and removal of impediments within the body and mind to good health of individuals—is of universal concern, therefore, to older Americans. They are less concerned, and rightly so, about remote philosophic debate than they are about actual delivery of service by the physician, dentist, nurse, pharmacist, physiotherapist and other health care professionals and the corollary availability of good hospitals, nursing homes, home health agencies and other facilities or organizations in their own communities.

Few, if any, would deny that substantial progress has been made in delivery of medical care to the aging. Noteworthy have been the Medicare and Medicaid programs which began in 1966. How can the successes and failures, the shortfalls and the advances, made under these programs offer better understanding of merits and deficiencies, respectively, within a service strategy or an income strategy?

More importantly, how can America, including its Government, best assure quality medical care for older Americans through most effective use of its public and private resources in being, or capable of development?

This broad question has long been of vital concern to the elderly. It becomes more timely as Congress turns attention to a variety of proposals for new Federal systems to finance medical care for all citizens. Both involve decisions about priorities and careful assessment of national potentials in health care.

How do Federal responsibilities for medical care to the elderly balance out against its responsibilities for others in determinations of priorities? Will the aging be better served as part of whole new approaches, or through prior expansion and improvements in Medicare and/or Medicaid? Apart from financing arrangements, should first priority be given to development of special new capacities in medical care for older persons? Or can the Nation meet these clear needs concurrent with efforts in this direction for all people?

Illustrative of implications in the latter, is a subsidiary question: Is it more important to strengthen home health care services for the elderly and improve institutional care services for those suffering from most serious chronic illnesses and disabilities, or to devote new energies to broader elements in medical care? Should Federal dollars to pay for care of the chronically ill or disabled aged, in or out of institutions, now largely ignored by Medicare and provided on a hit or miss basis by Medicaid, be first? Or will these unmet needs among older Americans be met more promptly and effectively through a new total health care package which also includes the young?

Regardless of how answers to such questions are developed, it is clear that there are many unmet health care needs among the aging. Within this more narrow context, what are the priorities for congressional action? What are the priorities for action by the private sector of society?

Among the medical needs of older Americans which are excluded from or inadequately covered by Medicare and which compete with each other for Federal dollars, and with other demands of both young and old, are the following: prescription drugs outside of institutions, non-emergency dental care and dentures, hearing aids, eyeglasses, and refractions, institutional care for nonacute illness or disability requiring no prior hospitalization and nonprofessional medically indicated support services in the home for nonacute illness or disability. What priorities should Congress give to each?

Covered under Medicare, but used only sparingly are home health care services designed in part to avoid high costs of institutional care, but more importantly to reinforce satisfying life situations and emotional health needs of older persons. What priority should be given to improvements and extensions of this crucial service vis-a-vis other forward steps? Are current inadequacies due to Federal reluctance to paying for such services, or due to other factors? Does the medical community understand the importance and availability of such serv-

ices? Do serious personnel shortages—nurses, medical social workers, physiotherapists, and others—contribute to deficiencies in use of home health care services? Does geographic distribution of essential personnel, including physicians, deny these services to older persons legally qualified for them under Medicare? If so, how extensive is this problem? What can be done about it?

In the face of unmet needs such as described in the foregoing paragraphs, what consideration should be given to elimination or reductions in premium charges, deductibles and coinsurance payments which currently are required of Medicare participants?

The limited extent of Federal response to medical needs of older Americans is shown by the fact that this program currently pays slightly more than 40 percent of the health care expenses of its beneficiaries. How clear a picture of the problem does the data give? What are the dimensions of unmet medical needs of older Americans through society's *total response* to them as reflected in such financial data? How much of the roughly 60 percent of health care costs not met by Medicare is picked up through Medicaid? How much is met through supplemental coverage offered by voluntary health insurance plans? How much of it is capable of budgeting by the individual who makes out-of-pocket payments?

Are there differences in medical need response based on geographic factors and the kinds of communities in which older persons live? How does effective response differ, particularly in terms of service delivery, in rural areas, inner cities and other types of communities? How does it differ for different racial or ethnic groups?

In short, what are the actual dimensions of the problem? How can Government or private forces meet the needs most effectively without comprehensive evaluation of all the facts, even while we take proper immediate steps to meet the most obvious problems?

Housing

Apart from medical care, one of the most easily identified factors in well-being is that related to housing. Consequently the elderly housing question has often been a focal point in the debate on a Federal income strategy as opposed to a strategy giving priority to services and facilities.

Problems in Federal housing programs are discussed in some detail in chapter V of this report, with special reference to S. 3066, the Housand Community Development Act of 1974, which has passed the Senate and hopefully will be approved by the House of Representatives and the President.

While S. 3066 reflects the Senate's view on one major aspect of Federal priorities in housing, need for action on behalf of the elderly with lowest incomes or with least adequate home and community situations, none would dispute that it leaves many unanswered questions.

"Income strategists" suggest that if older persons are provided adequate incomes or housing allowances the housing market will respond to their demand based on individual choices more suited to their happiness than decisions made by governmental bureaucracy. They also raise questions as to how fairly older persons with comparable needs

will be treated. To what extent are people with great need denied federally supported housing because of the accident of where they live? Are the poor elderly in rural areas, for example, discriminated against in favor of those in cities?

"Services and facilities strategists," on the other hand, make a strong case that elderly housing will not be built, especially for members of minority groups, the poor, the infirm, without categorical grants for construction and operating subsidies. They raise questions about use of allowances in the light of housing shortages which exist. Is there a sufficiently large present stock of housing to make use of allowances effective? Will rents be increased in anticipation of rent subsidies?

Our own attitude is demonstrated by our unanimous support of S. 3066. Even with full implementation of its provisions, however, we urge national recognition that more is needed, including wider use of the ingenuity of private financial institutions and commitments by them to better housing for the elderly.

Best solutions to housing problems among older Americans, as with responses to their other needs, should include recognition of their individuality. Housing efforts should be designed to offer alternatives which strengthen rather than restrict personal liberties. The views of older persons themselves therefore become more important.

To what extent are older Americans now satisfied or dissatisfied with housing they have? What kinds of priorities do they place on their own housing needs? What fears do they have related to their housing in their futures? How well are they meeting their needs through their own efforts?

Does the fact that roughly 70 percent of the couples and substantial numbers of single and widowed persons past 65 own their own homes, for example, indicate that their housing needs have been met? Are some of these older homeowners frozen into undesirable housing situations because alternatives are not available? Even as they remain in their homes, or try to, are they faced with special housing problems to which tax-supported programs should be addressed? If so, what should be the character of such efforts?

Going to the other end of the housing spectrum, what Federal emphasis should be given to support of institutional or congregate types or housing? How well is America responding to the fear common among older persons about what happens to them when they become too infirm or disabled to live alone? Has the emphasis in what is loosely described as institutional housing been directed too much at medically oriented facilities such as nursing homes and intermediate care facilities as defined under Medicaid programs? Has there been resistance by older persons to use of institutional facilities because too many are patient-oriented instead of person-oriented?

For many years religious groups and others have offered leadership in development of homes for the aged designed to offer all types of life satisfactions to their residents. How much use would older persons make of such facilities if they were more widely available? To what extent and in what form can Federal subsidies be of help in promoting these homes? Should subsidy be limited to construction costs or should it also include operating funds? If there are no operating subsidies, outside of medically based programs such as Medicaid, how can accept-

able congregate housing services be made available to older persons who are not affluent?

Widely differing opinions have been found among housing administrators as to whether individual housing units for the elderly should be placed within the larger community or segregated from the young. How do answers to this question relate to the ways in which future programs will develop? Do answers to it differ by reason of age within the older population, or family status, or state of health?

The question of *personal safety in public housing* has been a factor in arguments about segregated housing for the elderly. Can the admittedly aggravated security problem among the old be met successfully without an equally successful effort on behalf of all persons living in neighborhoods where the problem is most serious? If the total safety problem is met, what effect may that have on the attitudes of older persons toward segregated projects?

Many older persons, particularly single or widowed individuals, live with their adult children or other younger relatives. How does this bear on housing policies? Do we even know the extent to which such arrangements may be made through choice?

Is it not important, in development of answers to these housing questions and a myriad of others, to determine more accurately what older Americans in varying situations want? Should not efforts to determine such attitudes be made on the basis of probable choices they would make if offered a full range of alternatives?

Research

As we have raised questions, up to this point we have not used one word which is paramount in development of realistic national policies in aging. The word is research:

Can either individuals or society respond effectively to great and changing challenges in America's new era of aging without research? We think not.

Can the Nation continue to use a hit or miss approach on behalf of older Americans? Are not the issues so important to all citizens that comprehensive research is essential?

Research is the key to satisfactory solutions for both society and individuals. Application of research in this context should recognize all of the word's accepted definitions as found in the dictionary:[2]

> RESEARCH: 1; careful or diligent search; a close searching (*researches after hidden treasure*) 2 a; studious inquiry or examination; esp; critical and exhaustive investigation or experimentation having for its aim the discovery of new facts and their correct interpretation, the revision of accepted conclusions, theories, or laws in the light of newly discovered facts, or the practical applications of such new or revised conclusions, theories, or laws (*gave his time to research*) b(1); a particular investigation of such a character; a piece of research (2); a presentation (*as an article or book*) incorporating the findings of a particular research 3; capacity for or inclination to research (*a scholar of great research*).

[2] Webster's Third New International Dictionary of the English Language Unabridged, third edition, 1961.

As members of the Special Committee on Aging we have followed some of the distinguished work done in aging by research scholars in many disciplines. Their findings which have come to our attention have emphasized that issues in aging are neither simple nor static; they are complex and constantly undergoing dynamic change.

While we are aware of major contributions through research to better understanding of aging, we are most sensitive to inadequacies in information which has come to our attention. We are even more concerned that persons less favorably situated for acquisition of knowledge about progress and problems in aging are being denied the data and insights of research.

Is it not important that we strengthen current research efforts related to age? Is it not even more vital to America that there be a national effort to make use of research?

Even as we, in our responsibilities as members of the Senate, make decisions which must be made in response to immediate needs of older Americans, we believe that ultimate answers to the challenges in aging must be based on practical application of research findings and that there be a vigorous effort to continue and expand research now under way.

LONG RANGE POLICIES AND PUBLIC ATTITUDES

III. *How can the people as a whole, young and old, come to awareness of new 20th century implications of aging and their relationship to social policies and their own individual needs throughout life?*

It is estimated that within the next 75 years approximately 220 million Americans now living or yet to be born will have celebrated their 60th birthday. Within that 75 year period, it is foreseeable that the percentage of the total U.S. population aged 65 or over may rise to 15 percent or more.

It is estimated that 72 percent of the babies born during 1974 and 76 percent of persons now aged 30 will reach the age of 65. More than 69 percent of those *now* 65, 52 percent of those *now* 30, and 50 percent of the babies born this year are expected to attain ages beyond 75.

As one looks at these estimates, it should be noted that they are based on life expectancy calculations which cannot take into account future progress in disease control or other factors which may extend life. They are, therefore, more apt to understate than to overstate the probabilities.

It is clear from the foregoing estimates, that the problems of aging, or more properly the challenges of aging, are of personal significance to every man, woman and child in America. Decisions which will be made by them as individuals and as members of society will determine how they and this Nation use opportunities in aging today and tomorrow.

The question, "*How can all Americans be made aware of how aging policies affect them?*" therefore becomes most important.

Older Americans have recognized full well that the questions relating to aging are not their sole province. Policy statements by such important organizations representing older persons as the American

Association of Retired Persons, the National Association of Retired Federal Employers, the National Council of Senior Citizens, and the National Retired Teachers Association have consistently maintained a posture reflecting their concern for those now young.

How can the middle-aged and the young come to an understanding of aging's implications for them so that they may avoid some of the problems experienced by those now old? Do not the lessons learned by today's older Americans demonstrate that 19th century concepts of age are no longer valid?

The late Dr. Ethel Percy Andrus, founder and first president of the American Association of Retired Persons and the National Retired Teachers Association, was one of the first to voice the thesis that society faces a new era in aging. This distinguished educator put the issue in these words:

> Our generation of older folks is a pilot one. How it will be reported is a matter both of conjecture and interest. Shall we, pioneers in retirement living as a group, be portrayed as needing special assistance because we are needy, dependent or otherwise at a disadvantage? Or, can we live such rewarding and interesting lives that the report on our generation will stress the importance—to ourselves and to society—of our value to society in personal growth and community participation? . . .
>
> It is not enough to see man as an individual in the same way, as is an individual man in an army or a crowd. The difference is so great that there is a special word for an individual man, a word of power and importance; the word is "person." . . .
>
> It carries the thought that every man has individual duties to himself and to others. Also there is added, too, the idea that every man has individual rights that exceed those of the group of which he is a part. A man, because he is a person, may not be disregarded or cast out, like any other kind of individual, vegetable or mineral, in order to improve the group of which it is a part. In other words, here again we face the precept that the state exists for the man, not man for the state.

Orientation to Youth or All of Life?

Much has been made of the view that this nation is geared to youth. No group has given higher priority to the young than those who are now described as older Americans. The best interests of their children, grandchildren, and great grandchildren have been their preeminent concern. Habits of a long life-time have not nor will not change. Older Americans will continue to urge that first attention of society should go to the young because of the long vistas of life before them. The question rises, however: *What are those vistas?*

Is the prior right of youth in the social scheme only aimed at life up to age 30? Age 40? Age 50? Or is it to help them attain the best that is available *throughout* life? Is society preparing the young for

a life that loses meaning at 65 or 70? Are not these the kinds of questions that all of America should answer?

Is it not important for the young and middle-aged to face the prospect of age with confidence in its positive potentials instead of with fear?

Is it not apparent that positive responses by society to needs of older Americans today depends on new recognition by the young and middle-aged as to what senior years should be? Do not the decisions made now with full support by the young determine the character of their own lives? How can this message be brought home?

Need for a Well-Informed Populace

Leadership in this direction has been offered by major organizations now representing older Americans. Positive efforts have been forthcoming also from groups representing persons with special interests in aging, such as the American Geriatric Society, the Gerontological Society, and the National Council on Aging, each of which has made important contributions to the knowledge in aging.

Extensive research has been carried out, in addition, by the Aging Studies program, College of Social and Behavioural Sciences, University of South Florida; All-University Gerontology Center, Syracuse University; Center for the Study of Aging and Human Development, Duke University; Committee on Human Development, University of Chicago; Ethel Percy Andrus Gerontology Center, University of Southern California; Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University; Gerontology Center, Boston School of Medicine; Gerontology Research Center, National Institute of Child Health and Development; Institute on Applied Gerontology, St. Louis University; Institute of Gerontology, University of Michigan; Langley-Porter Neuropsychiatric Institute, University of California; Mid-West Social Research Council on Aging (a consortium of 14 universities in seven States); Rocky Mountain Gerontology Center, University of Utah; W. E. Upjohn Institute for Employment Research and other nonprofit institutes throughout the country.

Disciplines participating in such research embrace the whole range of human endeavor. How can we make fuller use of their work?

Within the governmental sphere, what responsibilities for helping all Americans to better understand the needs and challenges of aging should be assumed by the Administration on Aging, the newly formed Federal Council on Aging, the Administration's Interdepartmental Task Force on Research on Aging, the White House Domestic Council on Aging, or indeed this Senate committee?

It is reasonable to expect that all of the foregoing and similar private and public groups or agencies which have assumed advocacy roles on behalf of older Americans will continue to do so. But is this enough? Is there not need for new attention to these questions on aging which should be faced by more broadly based elements in society?

Can we expect the ultimate desirable goals for older Americans to be achieved without positive action by educators, clergymen, labor leaders, business leaders, journalists, and all others who participate in the opinion making process?

At the beginning of this statement we emphasized the view that life, to be fully enjoyed, must be regarded as a continuum. Our own decisions in support of legislation and other actions on behalf of older Americans will reflect the importance of this conviction.

IMPORTANT AS PROMPT GOVERNMENTAL ACTIONS TO MEET NEEDS OF OLDER AMERICANS ARE NOW, DEVELOPMENT OF A NATIONAL POLICY ON AGING CAPABLE OF MEETING CHALLENGES OF THE NEXT 50 OR 100 YEARS DEPENDS ON AN INFORMED PUBLIC.

We all, young and old, need to understand better the positive elements in aging. Therein lies the promise of the future as well as the present. We all need to make a firm commitment to promote the rights of older people as individuals, to give national recognition to them as *persons*.

HIRAM L. FONG,
CLIFFORD P. HANSEN,
EDWARD J. GURNEY,
EDWARD W. BROOKE,
CHARLES H. PERCY,
ROBERT T. STAFFORD,
J. GLENN BEALL, JR.,
PETE V. DOMENICI,
BILL BROCK.

APPENDIXES

Appendix 1

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. ACTION

FEBRUARY 19, 1974.

DEAR SENATOR CHURCH: In response to your request of December 21, 1973, 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,

CARLTON KAMMERER,
Assistant Director of ACTION, Congressional Affairs.

[Enclosures]

VOLUNTEERS IN SERVICE TO AMERICA (VISTA)

Volunteers In Service to America (VISTA) was originally authorized under Title VIII, Section 801, of the Economic Opportunity Act of 1964, as amended. The Program was transferred to ACTION in July 1971. It is now authorized under Title I; Part A; Section 101 of the Domestic Volunteer Service Act of 1973.

The purpose of VISTA is to strengthen and supplement efforts to eliminate poverty and poverty-related human, social and environmental problems by encouraging and enabling persons from all walks of life and all age groups, including elderly and retired Americans, to perform meaningful and constructive Volunteer services in agencies, institutions, and situations where the application of human talent and dedication may assist in the solution of poverty and poverty-related problems and secure and exploit opportunities for self-advancement by persons affected with such problems. Inasmuch as all of the problems of poverty experienced by other poor groups are experienced by the older poor, except that they are more severe; VISTA has always sought to meet their needs as well as to recruit older Americans as Volunteers. Presently 12% of all Volunteers are over age 50. Five hundred and thirty-eight were in training or serving in projects throughout the United States in September of 1973. They represent every profession and skill and bring to poor communities a wealth of experience and knowledge. These figures represent a 2-percent increase over last year or approximately 2,448 older persons have served as VISTA Volunteers since 1965.

VISTA is recruiting more older Volunteers. The emphasis on attracting the skilled Volunteer, is opening new opportunities for retired specialists to contribute their abilities to help others. In addition, VISTA has made special efforts to recruit, train, and select older poor persons as Volunteers to serve in their own communities.

Most VISTA activities include reaching older persons in every community. Both older and younger Volunteers are channeling the available skills and talents of older poor persons to increase both their incomes and sense of worth. For example, in Idaho, Volunteers are working to establish basic health services and organizing programs and other services for senior citizens; in Kansas,

they are working to provide meals on wheels and full information on Social Security; in Missouri, Volunteers are helping to set-up a transportation system for senior citizens in five counties; in Iowa they are working to rehabilitate senior citizen housing.

These are but a few examples of projects throughout the country where older Americans are making valuable contributions to the efforts of VISTA in order to help the poor communities help themselves.

The Foster Grandparent Program (FGP)

The Foster Grandparent Program provides opportunities for low-income persons, age 60 and over, to offer supportive person-to-person Volunteer services in health, education, welfare, and related settings to children with special needs.

The Program was originally developed as a cooperative effort between the Office of Economic Opportunity and the Department of Health, Education and Welfare (Administration on Aging). It was given a legislative basis in 1969 under Title VI, Part B, of the Older Americans Act of 1965, as amended. In July 1971 the Program was transferred to ACTION in accordance with Executive Reorganization Plan No. 1. Current authorizing legislation is Title II, Part B of Public Law 93–113, the Domestic Volunteer Service Act of 1973.

The Foster Grandparent Program is designed to meet the needs of two groups: the low-income aging and children with physical, mental, social, or emotional health needs. It is the major Volunteer program through which older persons can improve their economic condition while engaging in meaningful and productive service. This activity is intended to enable older persons to maintain a sense of personal growth and self-worth, to enrich social contacts, and retain physical and mental alertness. Foster Grandparents do not displace salaried staff, but complement staff care to special children with the love and personal concern essential to their well-being.

ACTION grants to support the operation of Foster Grandparent Programs are awarded to public or private nonprofit agencies and organizations except program settings where Foster Grandparents serve. These settings include institutions for the mentally retarded; correctional facilities; pediatric wards of general hospitals; schools, day care centers, private homes; and institutions for physically handicapped, emotionally disturbed, and dependent and neglected children. Foster Grandparents serve four hours a day, five days a week, and receive a small stipend for their service. They are also reimbursed for, or provided with, transportation and, where possible, are provided a nutritious meal daily. They are covered by accident insurance and receive annual physical examinations. An orientation and in-service training program is provided; and through the professional staff of each program, Foster Grandparents receive counseling on personal matters and information and referral services.

In fiscal year 1973, with an appropriation of $25 million, the Foster Grandparent Program expanded from 135 to 150 local programs in 50 States, Puerto Rico, the Virgin Islands, and the District of Columbia. This growth will permit 11,300 Foster Grandparents to serve 22,600 children each day in over 470 child care settings. During fiscal year 1974 ACTION expects to fund approximately nine new local programs supporting an additional 600 Foster Grandparents.

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 included 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 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-esteem 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. One Foster Grandparent, a retired typist, has helped a severely retarded cerebral palsy victim learn how to walk for the first time in his thirteen years. Another Foster Grandparent has taught a blind and hydrocephalic child to feed himself and talk; as a result of the Grandparent's efforts, the boy, who had not been home for years, is now able to visit at home for extended periods of time. And Jim, a child with severe hearing impairment and no speech, has been transformed from a withdrawn, silent loner into a curious, expressive boy able to communicate in sign language, thanks in part to the efforts of his Foster Grandparent. Numerous other examples attest to the ability of Foster Grandparents to train the "untrainable" and give reason for hope to the "hopeless."

The Foster Grandparent Program has provided many insights into the potential utilization of the elderly in community settings by demonstrating that older persons have the talent, skill, experience, and desire to serve their communities. This desire to serve was expressed repeatedly by older persons at the 1971 White House Conference on Aging. The Conference Section on Retirement Roles and Activities established this need as a national priority. Additional information can be obtained by writing ACTION/Foster Grandparent Program, Washington, D.C. 20525.

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 200,000 businessmen and women.

The Small Business Administration was the original founder and sponsor of the SCORE Program. In 1971 the Program became co-sponsored by the ACTION Agency under the President's Government Reorganization Plan that placed all Volunteer programs within one government body. Under this unique co-sponsorship, the Small Business Administration provides recruitment, public information, and new program direction. Business concerns requiring help are referred to SCORE chapters, numbering over 225 in January of 1974 by ACTION and the Small Business Administration.

Over 5,000 Volunteers are working in 50 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 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.

Community organizations, ex-convicts, and small municipalities have also been assisted by SCORE. For example, SCORE Volunteers have worked with the Red Cross as administrators in disaster areas, such as Harrisburg, Pennsylvania, after the floods in 1972. SCORE Volunteers work as counselors and sponsors to soon to be paroled convicts who are starting small businesses in Washington State. In Illinois, a SCORE chapter of retired State government executives has been assisting small municipalities in personnel systems, tax, and recreation problems.

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 Senior Companion Program (SCP)

The purpose of the Senior Companion Program is to provide meaningful opportunities for low-income persons, age 60 and over, to offer person-to-person supportive services to adults, especially older persons, living in their own homes and in residential and non-residential group care facilities.

The Senior Companion Program, an Older Americans Community Service Program, was originally authorized under Title VI, Part B, of the Older Americans Comprehensive Services Amendments of 1973. Current authorizing legislation

is Title II, Part B, of Public Law 93–113, the Domestic Volunteer Service Act of 1973.

The Senior Companion Program is expected to become operational in fiscal year 1974. A small number of ACTION grants will be awarded to public or private non-profit applicant agencies to sponsor pilot projects. Additional information may be obtained from ACTION/Older Americans Volunteer Programs, Washington, D.C. 20525.

The Retired Senior Volunteer Program (RSVP)

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.

Originally authorized under the Older Americans Act Amendments of 1969, RSVP became operational in 1971 when the Department of Health, Education and Welfare (Administration on Aging) funded eleven pilot projects. In July 1971 the Program was transferred to ACTION in accordance with Executive Reorganization Plan No. 1. Current authorizing legislation is Title II, Part A of Public Law 93–113, the Domestic Volunteer Service Act of 1973.

ACTION grants are awarded to local public agencies and nonprofit private organizations to support the development and operation of RSVP's providing Volunteer opportunities for persons 60 years of age and over. Either transportation, or assistance with the costs of transportation, is provided between the homes of Senior Volunteers and their Volunteer Stations. When Senior Volunteers serve over a meal hour, meals are available without cost to them at many Volunteer Stations. Accident insurance is provided for all RSVP Volunteers.

As an inherently local program, each RSVP is locally planned, operated, controlled, and supported. During the project period, which can be as many as 5 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 after 5 years.

Retired Senior Volunteer Programs encourage organizations and agencies to develop a wide variety of Volunteer opportunities for retired persons. The focal point of RSVP activity is the needs and interests of the Senior Volunteer, and Volunteer opportunities are arranged to match his interests, abilities, and physical capacities. Orientation or instruction for Volunteer assignments may be provided. Older adults, including the isolated elderly, are sought out and actively encouraged to contribute their time and experience in service to their communities. Handicapped older persons are included in the ranks of Senior Volunteers; special arrangements to facilitate their service are made when necessary. There are no income, education, or experience requirements for a retired person to become a Senior Volunteer.

Special assignments arranged for Senior Volunteers offer varied opportunities to serve people of all ages. 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.

In the last 2 years, with an annual appropriation of $15 million, the Retired Senior Volunteer Program has experienced truly dramatic growth. In the latter 6 months of fiscal year 1973 alone, the Program more than doubled in size to total 590 local RSVP's. These programs are located in all fifty States, Puerto Rico, the Virgin Islands, and the District of Columbia. Almost 65,000 Senior Volunteers were in service by the close of calendar year 1973, and as many as 100,000 are expected to be enrolled by the close of fiscal year 1974. ACTION expects to maintain the current level of Retired Senior Volunteer Programs, while the number of Senior Volunteers is expected to continue to increase as local programs become better established.

In December 1973, E. F. Shelly and Company, Inc., completed a study of the Retired Senior Volunteer Program. The study identified benefits derived from participation in RSVP by both Senior Volunteers and Volunteer Stations. Nearly three-fourths of the Volunteer Stations included in the study indicated that Senior Volunteers provided a valuable supplement to their staff, and nearly two-thirds stated that they would be forced to cut services or activities in the absence of Senior Volunteers.

More than half of the Senior Volunteers included in the study indicated that they felt better physically, and nearly four-fifths stated they felt better mentally, due to their Volunteer experience. In addition, study data indicated that a majority of Senior Volunteers lived alone and had little or no previous Volunteer experience; they therefore experienced an increase in community involvement and a reduction in isolation as a result of RSVP.

Numerous examples illustrate the value of the contributions of Senior Volunteers to their communities. A nurse writes, "All of the Senior Volunteers' achievements and contributions aid us in promoting the effectiveness and operation of our hospital in a more advantageous manner." The Director of Education at a State correctional school writes, "Three of our former students . . . were all tutored by RSVP Volunteers and the three all said they would not have finished high school or passed the high school equivalency test without this help." The director of two day care centers writes, "Because of the senior citizens, we have been able to provide an additional area of enrichment for our children in the centers." And the managing attorney of a legal services program writes, "Because of the RSVP Volunteers . . . and the competent and gracious assistance they are giving to us, we are able to serve a much larger number of clients in a much more professional atmosphere than would ever be possible in their absence." Countless other examples affirm that Senior Volunteers are serving their communities, and serving them well, in a variety of Volunteer activities.

For additional information on the Retired Senior Volunteer Program, write ACTION/RSVP, Washington, D.C. 20525. "Recommendations for Developing RSVP, the Retired Senior Volunteer Program," a 1971 study of senior Volunteer programs contracted for by the Administration on Aging, may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20502, for $3, by reference to Stock Number 5600–0001.

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 4 percent of all Volunteers (302) are 50 years of age or older, of whom 146 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.

ITEM 2. ADMINISTRATION ON AGING

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., February 16, 1974.

DEAR MR. CHAIRMAN: I am pleased to transmit herewith the requested report on activities of the Administration on Aging during 1973.

As you well know, with the passage of the Older Americans Comprehensive Services Amendments of 1973, and implementation of the national Nutrition Program for the Elderly, the past year has been an exceptionally important one for AoA. It is hoped that our report adequately reflects the significant activity of this period.

The Administration on Aging appreciates the opportunity to cooperate with the U.S. Senate Special Committee on Aging in the preparation of the 1973 Developments in Aging.

Very sincerely and cordially yours,

ARTHUR S. FLEMMING,
Commissioner on Aging.

[Enclosure]

THE ADMINISTRATION ON AGING (AoA)—CALENDAR YEAR 1973

A number of important developments for the Administration on Aging occurred in 1973, the most significant of which was the signing by the President

on May 3, 1973 of Public Law 93-29, the "Older Americans Comprehensive Services Amendments of 1973".

On April 1, 1973, by order of the Secretary, AoA was transferred from the Social and Rehabilitation Service (SRS), of which it had been a component since the SRS was created in 1967, to the new Office of Human Development (OHD), in the Office of the Secretary. Since its creation effective on that date, OHD has been headed by the first Assistant Secretary for Human Development, Hon. Stanley B. Thomas, Jr.

Another change effective April 1 was the departure of John B. Martin, who had resigned as Commissioner on Aging, in which capacity he had served since mid-1969. Shortly thereafter, President Nixon and Secretary Weinberger announced the nomination of Dr. Arthur S. Flemming as Commissioner Martin's successor. Dr. Flemming was confirmed by the Senate, without opposition, and was sworn in as the third Commissioner on Aging on June 19, 1973.

A. State and Community Programs on Aging

Throughout most of 1973 the Title III State and Community Program on Aging continued to function under authorization of the Older Americans Act as amended in 1969. The year 1973 may be viewed overall as a period of significant transition in the area of State and Community aging programs, toward more comprehensive planning and coordination of aging resources in order to lay the necessary groundwork for timely implementation of the new Title III State and Community Program, once new amendments were enacted. The President on May 3, 1973 signed into law the Older Americans Comprehensive Services Amendments of 1973. Title III of these amendments has as its objective the development of a comprehensive and coordinated system for the delivery of services to older persons at the State and sub-State levels.

Prior to the amendments of 1973, the Older Americans Act provided support for discrete services designed to respond to particular needs of older persons in scattered local communities. Under the 1969 amendments, a program of Area-wide Model Projects had been initiated to test the viability of providing a network of coordinated service systems to serve older persons. Building upon the most successful experience of these programs, the 1973 Amendments were designed to begin the development of a national initiative directed toward providing comprehensive and coordinated service systems for older persons, with great stress placed upon enhancing the capability of State and sub-State agencies to plan and implement programs that will increase the utilization of available and potential services and resources on behalf of older persons.

1. STATE PLANNING

In anticipation of the passage of new amendments to the Older Americans Act, State Agencies on Aging undertook State-wide surveys of their aging population to determine concentrations of older persons with the greatest social and economic need and to assess the availability of resources to meet the identified needs. Some State Agencies on Aging divided their States into planning and service areas in preparation for development, within areas of highest priority, of action plans for promoting comprehensive and coordinated systems of service for aging persons. Concomitantly, State Agencies on Aging began to build up their staffs and to develop overall staff capacity through training programs in preparation for the greatly expanded responsibilities which they were shortly to assume.

The overall objective of the new Title III program is to strengthen or to develop at the State or area level a system of coordinated and comprehensive services for older persons—services which will enable older persons to live in their own homes or other places of residence as long as possible.

In order to achieve this objective, the program is designed to strengthen State Agencies on Aging in the discharge, among others, of the following responsibilities:

—to become the focal point in the State on behalf of older persons;

—to carry out those activities necessary for effective planning on behalf of older persons, including the establishment of measurable objectives for aging programs;

—to establish such procedures and mechanisms as are necessary to assure the effective coordination of all State planning and service activities related to the field of aging;
—to provide for ongoing monitoring and assessment and to conduct periodic evaluations of activities and projects in the field of aging, with special emphasis on the work of Area Agencies on Aging;
—to assure, in cooperation with Area Agencies on Aging, the availability of information and referral sources in sufficient numbers so that all older persons will have reasonably convenient access to such sources by the end of fiscal year 1975.

To be eligible for grants under Title III, a State Agency on Aging, prior to the beginning of each fiscal year, is required to submit a State plan to the Commissioner on Aging for approval. The plan is to be developed by the State Agency designated by the Governor and then approved by the Governor prior to submission. Its specifications are set forth in regulations and guidelines promulgated by the Administration on Aging.

Included in these specifications are the following:
—a statement of the measurable objectives, in priority order, established for the Title III program;
—a plan of action for discharging the responsibilities set forth earlier in the document;
—a plan for bringing about maximum possible coordination between the resources available under the Adult Social Services and Medical Care Titles of the Social Security Act and the operation of the programs under Title III;
—the division of the State into distinct planning and service areas;
—an identification of those planning and service areas in which Area Agencies on Aging will be designated and area plans developed during the fiscal year with priority consideration being given to those areas having significant concentrations or proportions of low income and minority older persons 60 years of age or older;
—an identification of the needs of the older persons within the State and the resources available to meet such needs.

2. AREA PLANNING AND SOCIAL SERVICES

Prior to the enactment of the 1973 amendments, State agencies funded service programs in accord with the differing needs of each community regarding aging-related services. More than 1,700 projects were in operation during the year.

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 community services made it possible for elderly persons to maintain a sense of dignity and independence in their own communities. In-home services include homemaker services, home-health aides, escort services, friendly visiting, chore services, telephone reassurance, home repair and delivered meals.

Transportation is a major component of any service aimed at maintaining independent living, since it frequently means the difference between isolation and community involvement. Many of the community programs offered point-to-point transportation to make it possible for elderly persons to receive necessary care and participate in social and recreational activities. The community programs used buses, radio-equipped mini-buses, cars and other vehicles. These programs enabled the elderly to keep medical appointments, visit senior centers, participate in congregate meals, shop for groceries, attend religious and social activities and reach information centers for counseling and referral to service providers.

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 homemakers/home-health aides under the supervision of a registered nurse, provided nursing and personal care as well as light housekeeping. Other community 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.

Volunteers, many of whom were 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.

Even as these direct service programs were being carried out, planning was underway in 195 communities across the country in preparation for the new Title III program. Twelve-month planning grants, awarded at the end of 1972, had as their purpose the development of local readiness to initiate Area Agencies on Aging once new legislation and funding became available, and to lay the groundwork for the Title VII Nutrition Program.

Title III of the Older Americans Act Amendments of 1973 establishes a new program that addresses the failure in most communities to systematically pool the resources and services that are available for older persons and to focus them in such a manner as to make a significant impact on the lives of those persons. The 1973 amendments provide the mandate for development of a network of agencies which are to be designated as Area Agencies on Aging across the country. The law provides that the State may designate a public or non-profit private agency or organization as an Area Agency on Aging. The State is required, however, to give preference to an established office on aging, where such exists.

In order to be eligible for grants under Title III, an Area Agency on Aging, prior to the beginning of a fiscal year, is required to submit a plan to the State Agency on Aging for approval. The specifications for the plan are set forth in regulations and policies established by the Administration on Aging.

Included in these specifications are the following:

—a plan of action for discharging the responsibilities set forth in the legislation;

—an operating plan that will give priority to those activities and services which will assist and benefit low income and minority older persons throughout the planning and service area, and will assure, to the extent feasible, that low income and minority individuals will be served at least in proportion to their relative numbers in the planning and service area;

—a plan for bringing about maximum possible coordination between the resources available in the planning and service area under title III and those available under the Adult Services and Medical Care Titles of the Social Security Act;

—a plan for demonstrating to local governmental units how the priority established under General Revenue Sharing for social services for the poor or aged can be used in such a manner as to inaugurate new or strengthen existing services for older persons;

—a plan for endeavoring to work out arrangements under which recipients of grants or contracts for nutrition projects mutually agree with the area agency that such nutrition projects shall be made a part of the area's coordinated and comprehensive service system for older persons.

The State is authorized to award funds to projects in planning and service areas where Agencies on Aging have not been designated. These projects must be of such nature, however, as to contribute to achieving the purposes set forth in title III. These purposes include the concentration of resources in order to develop greater capacity to meet the needs of aging persons, and the development of comprehensive and coordinated service systems to serve older persons. High priority is placed on the use of funds to assure that older persons in each area have reasonably convenient access to information and referral services.

3. AREAWIDE MODEL PROJECT PROGRAM

The Areawide Model Project Program, which was authorized by the 1969 amendments to the Older Americans Act, provided discretionary grants and contracts with State Agencies on Aging for the conduct of projects in selected geographic areas for the purposes of developing and testing innovative approaches in the planning and delivery of services to older persons.

The program was formally initiated at the end of fiscal year 1971 with the approval of the first nine Areawide Model Projects. Subsequently in fiscal year 1972, 12 additional projects were funded. By the end of fiscal year 1973 the 21 projects were in their first or second phase of program implementation. Of these projects, nine were operated directly by State Agencies, and 12 others have been sub-contracted by State agencies to public or private organizations in the designated areas.

In fiscal year 1973, the 21 Areawide Model Projects provided a variety of services in a coordinated fashion to meet the needs of the elderly in the selected geographical areas. Several service components common to most of the projects are information and referral services, transportation, food and nutrition services, health services and recreation activities. Other services provided included homemaker, home health care, handyman services, housing assistance, counseling and social services, education including consumer education, telephone reassurance, job placement, library services and legal assistance.

The Areawide Model Project concept became the prototype for the comprehensive and coordinated service systems for older persons, called for in the 1973 amendments to the Older Americans Act. In view of this new strategy and higher level of funding authority provided in the new Amendments for Title III, the 21 Areawide Model projects have been incorporated into the Title III Area Planning Social Services network in fiscal year 1974. It is expected that these 21 projects will provide the cornerstone for the establishment of comprehensive and coordinated programs for older persons in the newly designated planning and service areas.

4. MODEL PROJECTS ON AGING

The 1973 Older Americans Comprehensive Services Amendments to the Older Americans Act provide for a new Model Project program. The Commissioner is authorized to enter into contracts with or make grants to any public or non-profit private agency or organization within a State, after consultation with the State Agency on Aging, to pay part or all of the cost of developing or operating statewide, regional, metropolitan area, county, city or community model projects which will expand or improve social services or otherwise promote the well-being of older persons. Special consideration is given to projects which: (1) assist in meeting the special housing needs of older persons; (2) provide continuing education to the elderly; (3) provide pre-retirement education, information and related services to the elderly; and (4) provide services to assist in meeting the particular needs of the physically and mentally impaired older persons including special transportation and escort services, homemaker, home health and shopping services, and other services designed to assist such individuals in leading a more independent life.

Implementation of the Model Projects Program began in fiscal year 1974.

5. NUTRITION PROGRAM (TITLE VII)

The Nutrition Program had its origin in 1968 with the appropriation of funds under Title IV of the Older Americans Act for a research and demonstration program to improve nutritional services for the elderly. These Title IV projects demonstrated the utility of congregate meals in providing older persons with opportunities for social interaction, facilitating the delivery of social services and improving nutrition for the elderly.

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 socialization needs of individuals, aged 60 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 to prepare and eat a meal alone.

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 largely in congregate settings, at strategically located centers.

These centers can be located in facilities such as: schools, churches, community centers, senior 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 Title VII project must provide at least one hot meal per day, 5 or more days per week, and each 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, low-income and minority elderly 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. In addition, AoA has instituted an information and reporting system to assure that the low-income and minority elderly are given priority service. Supporting social services must be developed within 30 days after nutrition services have been initiated. To the maximum extent feasible, the project must make every effort to utilize 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.

In view of the current pressing needs of some of the elderly for nutritional services, the Title VII regulations were amended to encourage the prompt initiation projects and the start of their essential work of serving nutritious meals to the elderly. This amendment allows, under certain conditions, the postponement of the application of certain standards for nutrition projects in order to implement the program more rapidly. In preparation for the implementation of this program, the Administration on Aging has completed plans for in-service training of Project Directors and major Site Managers of Nutrition Programs for the Elderly. The training program was pilot-tested at Corvallis, Oreg., in cooperation with the School of Home Economics at Oregon State University. Also, five Regional training centers were established and are conducting the training. They are: New England Center for Continuing Education, Durham, N.H.; Community Nutrition Institute, Washington, D.C.; North Texas State University, Denton, Tex.; University of Nebraska at Omaha, Omaha, Nebr.; Oregon State University, Corvallis, Oreg.

As a part of the training program, a "Guide to Effective Project Operations" was developed for use by agencies, organizations, and institutions which will be operating nutrition projects. This guide is designed to convey basic information regarding major aspects of the Nutrition Program for the Elderly, and to provide technical assistance in program operations. A Nutrition Information System was developed, and training was provided to regional office and State agency staff regarding the installation and management of the system. Until the Nutrition Information System is fully operational, a weekly reporting system will provide a national summary of Title VII program progress.

Fiscal year 1974 is the first year of operation for the Title VII program, since funds were not appropriated until July 1, 1973. As of January 4, 1974, State agencies had awarded $99,600,000 of the fiscal year 1973 Title VII allotments to fund 648 nutrition projects, 195 in rural settings and 453 in urban areas. Once these projects become fully operational they will serve 212,000 meals daily to older Americans. Seventy percent of the meals are being served to elderly persons with incomes below the Department of Commerce poverty threshold.

Technical assistance was provided to State Agencies and potential project grantees in each region to aid them in developing State plans and to prepare for implementation of the Nutrition Program. Forty-nine States, Puerto Rico, Guam, the Virgin Islands, and the District of Columbia submitted State plans which were approved. As of early 1974, American Samoa and the Trust Territories of the Pacific are not participating in the Nutrition Program.

B. Inter-Agency Coordination

Important developments in the area of inter-agency coordination include the creation of the Interdepartmental Working Group of the Cabinet-level Domestic Council Committee on Aging, of which the Commissioner on Aging is chairman, and the Committees on Aging of the Federal Regional Councils. The objective of these new Inter-Agency authorities is to facilitate research, planning and program initiatives across organizational boundaries to accelerate the development

of the comprehensive and coordinated system of services called for in the 1973 amendments to the Older Americans Act.

The 1973 amendments direct AoA to "coordinate, and assist in, the planning and development by public (including Federal, State, and local agencies) and non-profit private organizations of programs for older persons, with a view to the establishment of a nationwide network of comprehensive, coordinated services and opportunities for such persons." The amendments also strongly emphasize coordination of Federal resources and services at the State and sub-State levels by State and Area Agencies on Aging to improve the social service system for older persons.

In addition to the new inter-agency responsibilities mandated to AoA by the 1973 amendments, the Administration on Aging is continuing those interagency agreements which were initiated in fiscal year 1973. Within HEW, joint projects continue with the Health Services and Mental Health Administration (now the Health Services Administration) Office of Education, and Social Security Administration. Cooperative activities are also in progress with Housing and Urban Development Transportation, and the Veterans Administration.

1. AOA-HSMHA COOPERATION

Under the AoA-HSMHA agreement, joint efforts were focused on cooperative funding of research and demonstration grants, health technical assistance by HSMHA Regional offices to areawide model projects funded by AoA, AoA assistance with the nursing home ombudsman program, planning for long-term care and alternatives to institutionalization, and development of a HSMHA objective calling for joint action in health planning.

In several regions the HSMHA and AoA regional staffs collaborated on the development of health components in areawide model projects, and established other informal working agreements. AoA and the Mental Health Administration also worked with the newly created Division on Aging of the National Association of State Mental Health Directors to try to effect cooperation with State agencies on aging.

The Administration on Aging continued to work with the six nursing home ombudsman programs, five of which are funded by HSMHA and one jointly by HSMHA and AoA, to review progress, promote State agency on aging cooperation, and confer with the ombudsman staffs regarding program development. AoA also worked with HSMHA, the ombudsmen, and the HEW office of Mental Retardation Coordination to point up problems of mentally retarded patients in nursing homes as reported by the ombudsmen.

In fiscal year 1973, four new research and demonstration projects were added to the seven previously funded under the AoA-HSMHA joint funding agreement. Two of the new projects relate to mental health of the elderly and the other two are concerned with improved geriatric and nursing home care.

2. AOA-OFFICE OF EDUCATION COOPERATION

During the year the Administration on Aging worked with two bureaus in the Office of Education on cooperative programs: the Bureau of Libraries and Learning Resources and the Bureau of Adult Vocational and Technical Education.

AoA cooperated with the Bureau of Libraries and Learning Resources on a demonstration project utilizing the branch libraries in five metropolitan communities as information and referral centers by providing expertise from the AoA statewide information and referral project in Wisconsin. An interchange of experience and findings of benefit to both the Bureau and AoA has continued.

With the Bureau of Adult, Vocational and Technical Education AoA explored the use of the network of teachers of home economics as a resource in the nutrition education program mandated under Title VII of the Older Americans Act. This resulted in a joint AoA-BAVTE memorandum to State Agencies on Aging and State Supervisors of Home Economics Education urging joint efforts "to promote optimal nutritional status among elder citizens through cooperative programming, literature and all other appropriate means." AoA also fostered consideration within the Bureau's Division of Adult Education, which resulted in the agreement that older adults, age 45 and above, constitute a group whose needs should be more adequately addressed in Special Projects funded under

the Adult Education Act. Such an agreement is reflected in priorities for fiscal year 1974 as published in the Federal Register.

3. AOA-OFFICE OF CONSUMER AFFAIRS COOPERATION.

Consumer education for older persons is one of the supportive services provided by the Title VII nutrition program. Following the President's 1972 message to the Congress on action for older Americans, which included a directive on the development of consumer education programs for the elderly, the Administration on Aging and the Office of Consumer Affairs cooperated in responding. The Office of Consumer Affairs developed a pamphlet entitled, "An Approach to Consumer Education for Adults" with a section on the Elderly Consumer. That Office in conjunction with the Administration on Aging and the HEW Office of Consumer Affairs met with the Federal Executive Board Consumer Committees relative to programs for elderly consumers. The Federal Executive Boards, located in 25 major cities and made up of heads of all Federal agencies in the city, are working on plans for cooperative programs aimed at older consumers in conjunction with area agencies on aging.

4. AOA-SOCIAL SECURITY ADMINISTRATION COOPERATION

AoA continued to work with the Social Security Administration on information and referral services. SSA had been given responsibility for providing information on all Federal aging programs by the President during the White House Conference on Aging. AoA also worked with Social Security on distribution to State Agencies on Aging of informational materials concerning the Supplemental Security Income program. A special project called "SSI-Alert" has been developed and is being implemented by AoA and SSA to alert potentially eligible older people to the SSI benefits and options. Also involved are the American National Red Cross and six major national organizations of older persons.

5. AOA-HUD COOPERATION

AoA and the Department of Housing and Urban Development continued to collaborate at the Federal and Regional levels. Efforts were also continued by AoA, HUD and the Law Enforcement Assistance Agency on security for the elderly in housing projects. Meetings were held with the American Association of Retired Persons on security following the AARP addition of staff to work on security for the elderly. This topic was also chosen as one of the priorities by the Region II, Mid-Atlantic Federal Regional Council Human Resources Committee's Task Force on Problems of the Elderly. Also, during the year, AoA and HUD continued to meet on possible joint funding of research and demonstration grants. AoA in cooperation with HUD made a training fund grant to the National Center for Housing Management for the training of managers of housing for the elderly. Three groups of managers were trained during the year.

6. AOA-DOT COOPERATION

The Administration on Aging and the Department of Transportation continued to work together on the transportation problems of the elderly. DoT appointed a coordinator for problems of the elderly and handicapped. Together, AoA, DoT, and the Connecticut Department of Transportation funded a model project to test a service to improve access to and use of health and social services. By agreement between Dot and AoA, AoA funded a grant to the Institute of Public Administration to analyze policies and research needed for further demonstrations of transportation services for aging.

7. AOA-VA COOPERATION

The Administration on Aging and the Veterans Administration continued the exploration of ways in which they could cooperatively assist older veterans and older persons generally. A plan was developed by AoA and VA central office staffs to try to involve VA facilities staffs in the planning and development of services in the Areawide Model Projects. To test the plan, visits were made to the Tucson, Ariz., and Syracuse, N.Y., Areawide Model Projects where joint meetings of VA and Areawide Model Project staffs were held and cooperative

efforts initiated. In Syracuse, the VA also began the examination of possible joint research between VA and the AoA gerontology centers. One further joint visit is planned in preparation for possible VA instructions to facility staffs calling for cooperation with area agencies on aging. Both the Tucson and Syracuse projects showed that the services were benefiting substantial numbers of veterans in the communities and helping prevent institutionalization.

8. RETIREMENT PLANNING PROGRAMS

The Administration on Aging continued to assist various Federal departments and agencies in the development and presentation of retirement planning programs. AoA provided background materials to departments and agencies for inclusion in kits given to participants in retirement planning programs. AoA also worked with the General Accounting Office on a proposed study and monitoring of retirement planning programs offered to Federal employees.

9. AOA-INTERFAITH COOPERATION

AoA has provided continued assistance to The National Interfaith Coalition on Aging, which was organized as an outgrowth of the White House Conference on Aging Section on Spiritual Well-Being and of preliminary work with the denominations by AoA. During 1973, the Coalition began the establishment of an operating base and budget for staff. It also set up a special research division to manage the research into services to the elderly by churches under a grant of Title IV research funds made by the Administration on Aging. At its annual meeting held in Washington during May—Senior Citizens Month—the Coalition leaders consulted with the Commissioner and staff on church participation in the Title VII nutrition program and in area agencies.

The primary objectives of the Coalition are:

(1) To develop an awareness of and to vitalize the role of the church and synagogue with respect to their responsibilities in improving the quality of life for the aging.

(2) To identify and give priority to those programs and services for the aging which best may be implemented through the resources of the Nation's religious sector.

(3) To stimulate cooperative and coordinated action between the Nation's religious sector and national secular private and public organizations and agencies whose programs and services relate to the welfare and dignity of aging people.

(4) To encourage the aging to continue giving to society from the wealth of their experiences and to remain active participants in community life.

AoA has also worked with the denominational members of the coalition as opportunities arose, such as with the Task Force on Voluntary Service, Presbyterian Church—United States; on older persons and voluntary service. Since the Coalition began its work, a Division of Gerontology of the Union of American Hebrew Congregations has come into being.

C. Research and Demonstrations

The Administration on Aging's research and demonstration program supports projects which add to existing knowledge in a wide variety of areas that are critical to the development and improvement of aging programs. The primary source of funding for research and demonstration projects in aging is Title IV of the Older Americans Act. Prior to AoA's move from the Social and Rehabilitation Service during April 1973, funding support was also received from Sections 1110 and 1115 of the Social Security Act.

Title IV of the Older Americans Act provided grants for approximately 25 new projects for the study of problems of elderly people and the delivery of services to them during fiscal year 1973. 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. For example, building on substantial research in progress, the Office of Elder Affairs in Boston began a demonstration on 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 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 funds authorized by Title IV. Older Americans Act, and Section 1110, Social Security Act. 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 predominantly within an institutional setting. The project sponsored by the Burke Rehabilitation Center in White Plains, N.Y., 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 a 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 Research and Demonstration. 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 services agencies, with the overriding objectives of enhancing programs which will enable the elderly to remain in their own homes. 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, Ga., 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 Inter-Study 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 improve 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 simple psychological instrument that is valid and reliable for measuring personality characteristics in middle-aged and older people is being developed. In the area of minority concerns, 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 1972 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 in process 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 are not currently being met by existing programs but which were identified by the White House Conference on Aging.

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, and program planning. The Gerontological Society began work on state-of-the-art papers on key social policy needs, possible alternative 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 1973. 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. Support of research on transportation for the elderly and handicapped in the Naugatuck Valley of Connecticut was continued. A study of the supply and demand of jobs suitable for older workers is being carried out by the Human Resources Center, Albertson, New York, under Section 4A of the Vocational Rehabilitation Act.

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 considerable progress in 1973.

In keeping with the substantial new responsibilities accorded to the Administration on Aging by the 1973 amendments to the Older Americans Act, high priority for the use of funds made available to the AoA for research in aging during fiscal year 1974 is being placed on projects that are designed to help those persons at the regional, State and area levels who are charged with the implementation of Title III. Of priority interest is research directed to the solution of problems which are barriers to the effective development of coordinated and comprehensive service systems for older persons at the State and sub-State levels.

D. Training

Prior to the 1973 amendments to the Older Americans Act, Title V of the now expired legislation provided for a training grant program which, from its inception in 1966, had as its objective the recruitment and preparation of manpower required for expanding the programs, facilities, and services called for in the Older Americans Act of 1965. Specific manpower activities included career education, short-term training, development of training materials, conferences, and studies to assess needs in the field. In 1973 the following manpower activities were in progress.

1. Career education in aging

Most of the career training programs in aging were initially established at the graduate levels. In 1973 support was provided for training at the baccalaureate, master's and doctoral levels.

The objectives of the career development program were to prepare practitioners for State and Federal program planning and administration, community development and coordination, management and administration of retirement housing and homes for the aged, senior center direction, teaching and research, and for serving older people through adult education, architectural design, counseling, law, library service, recreation, and other relevant fields.

Each career-oriented training program included an intensive practicum of from 3 to 9 months. Students and graduates have demonstrated to program agencies the value of personnel who have systematic knowledge of the aging processes and of older people. An evaluation study commissioned by AoA in fiscal year 1973 showed that most graduates of the training programs have readily found employment in the field.

Administration on Aging-supported career training programs have from their inception sought to recruit students from all minority groups. In fiscal year 1973 eight continuation awards were made to minority institutions or others with programs specifically focused on minority students. Approximately 22 percent of the students enrolled in career programs during 1973 were from minority groups.

One award, made in fiscal year 1972, supported a conference in 1973 for minority faculty persons entering the field of aging. The preparation of a text about elderly blacks, supported by a grant in fiscal year 1972, is scheduled for completion by the end of fiscal year 1974.

In fiscal year 1973 AoA supported career training programs in 47 institutions. These included 34 programs which offered interdisciplinary education for one or more of the priority areas listed above, with specialization in gerontology. In addition, 13 awards were made to schools of social work to prepare students for community development to meet the needs of the older population.

In the 47 programs, approximately 400 students will receive traineeships from fiscal year 1973 funds for education in the 1973–74 academic year.

2. MULTIDISCIPLINARY CENTERS IN GERONTOLOGY

The 1973 amendments add a new provision, Title IV, Part C, for the support of multidisciplinary centers on aging. Funds for support of such centers however, have not been requested. Under previous authority, the Administration on Aging has provided funds to at least one major institution within each Region toward the support of a multidisciplinary gerontological center. The underlying AoA objective grew out of the recognition that several such centers were making 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.

3. SHORT-TERM TRAINING

AoA has in previous years supported a number of short-term training programs. These have offered training ranging in duration from a few days to 14 weeks. They have provided intensive education in gerontology and in a variety of skills to several hundred persons recruited from all parts of the country.

Support for short-term training was expanded in 1973. Major emphasis was placed on the development of curricula, training materials, and training specifically designed to help prepare State and Area Agency on Aging and nutrition project personnel for effective implementation of the Older Americans Comprehensive Services Amendments of 1973. Grants for this purpose were made to one institution in each region, including eight multidisciplinary centers in gerontology. Training programs of from 3 to 10 days will utilize AoA-developed curricula to train an estimated 3,000 persons by the end of fiscal year 1974.

4. OTHER SPECIAL PROJECTS

Three projects with great potential significance which were initially funded in fiscal year 1972 received supplemental awards in 1973. The grant to the American Association of Community and Junior Colleges enabled the Association to: (1) compile an inventory of the extent of involvement of its 1,100 member colleges in the field of aging; (2) develop curriculum models for preparing semiprofessional personnel for the field; and (3) bring college personnel together with State and local aging agency personnel to develop mechanisms for collaboration.

A supplemental award to the National Center for Housing Management covered the costs of including specialized content on aging in training managers of housing for elderly. A curriculum being developed under this award is expected to be available for nationwide use by community and junior colleges and other adult education facilities.

The other supplemented award was made to the International Center for Social Gerontology in partial support for an international symposium on Housing and Environmental Design for Older Adults. The symposium was held in Washington, D.C., in December, 1973.

E. National Clearinghouse on Aging

A major event of 1973 was the establishment of a National Clearinghouse on Aging within the Administration on Aging in response to a directive set forth in Title II of the Older Americans Comprehensive Services Amendments of 1973. The clearinghouse is charged with (a) collecting, analyzing, and disseminating information about older people and their needs, (b) providing information to agencies and organizations with respect to programs for older persons, (c) encouraging the establishment of State and area information centers and referral services, (d) carrying out a program of consumer education for older people, and (e) stimulating other agencies to prepare and disseminate information for the field of aging.

The clearinghouse was organized with four units: Data Analysis and Dissemination, Public Information, Public Inquiries and Publications Distribution, and Information and Referral. A staffing plan was developed within the limits of AoA's resources and descriptions were prepared for several new positions required by expanding activities.

1. DATA ANALYSIS AND DISSEMINATION

During 1973, AoA continued to provide a variety of quantitative information about older people and programs for them, to planners, program administrators, researchers, and others within government agencies at all levels and to personnel of non-Government organizations. The activities are described as follows:

a. Development of Resources

Cooperative arrangements with all data collecting and tabulating agencies were continued and reinforced to promote the exploitation and distribution of data and findings concerning the older population, especially in view of the flow of data from the 1970 census enumeration.

During 1973, an effort was made to support the thrust of the Older Americans Comprehensive Services Amendments of 1973 which provide financial assistance to sub-State units planning for comprehensive and coordinated services to older persons. In an effort to help provide "small area" data as an essential input to the State and sub-State planning process, the Administration on Aging 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 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, AoA 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.

The Older Americans Comprehensive Services Amendments of 1973 established age 60 and over as the base for the State allotment formulas, rather than the former 65 and over. Data on the characteristics of the 60–64 age group are very scarce. What data are available tend to indicate that the individuals aged 60–64 are different in important aspects from those aged 65+. For example:

	65+	60–64	Ratio of persons 60–64 to persons 65+
Men in labor force (percent)	25.0	74.0	
Women in labor force (percent)	10.0	36.0	
Persons (millions, mid-1970)	19.3	8.4	44.0
Percent in families	69.8	81.6	51.0
Percent living alone or with nonrelatives	30.2	18.4	27.0
Percent who are spouses	20.4	32.3	69.0
Percent female relatives of head but not wife	9.0	3.8	18.0
Number living in "poor" households (millions)	4.7	1.1	24.3

In addition to discussions with the Census Bureau concerning future tabulations that permit breaking out the 60–64 age group for analysis of both the 65+ and the 60+ totals, special negotiations were completed on:

(1) Reconciliation of the differences in the reported numbers of persons 65+ in the various 1970 census reports because of sampling differences.

(2) Correction of errors in OEO computer tabulations of Census Bureau tapes that gave us detailed data on "the aged poor" by State, by color, and by urban-rural resident based on 1969 income as reported in the 1970 census enumeration.

(3) Reconciliation of the differences between estimates of the aged poor in 1969 as derived from the 1970 census enumeration and from the March 1970 Current Population Survey, resulting primarily from sampling and some definition differences.

(4) Special arrangement whereby the Census Bureau will supply to AoA in December of each year estimates of the 60+ and 65+ populations in each State as of July 1, of that calendar year for more accurate computation of State allotments under the Older Americans Act and for general data use.

(5) Advance data on income and poverty in 1971 and 1972 for analytical purposes and a special summary of income distributions for the total under-65 group to facilitate comparisons.

Negotiations were conducted on:

(1) Developing with HUD a conceptual basis to arrive at a measurable definition of "need" for housing for older persons. As a first step, tentative agreement was reached on a working definition for future testing of the concept "need for Federal assistance" in terms of the availability of housing in the community at a rental not exceeding 25 percent of the income of the older adults.

(2) Amendment of a new annual survey of housing to permit tabulation of data for older persons and identification of areas of concern or conditions that are most important to older persons.

(3) Joint agreement with the Housing Division of the Census Bureau which led to publication of a volume of tabulations on "Senior Citizen Housing" which will include cross-tabulations with data from the Census of population.

(4) Joint planning for an analytical and resource publication which was distributed at the International Symposium on Housing and Environmental Design for Older Adults in December 1973 in Washington, D.C., conducted by the International Center for Social Gerontology.

At a series of meetings with staff members of the Senate Special Committee on Aging and of the National Council on the Aging, an informal procedure was developed for exchange of information and publications in order to avoid duplication of effort and waste of scarce technical staff capacity.

Negotiations continued with two agencies in the Department of Justice concerning the collection, tabulation, and reporting of "age of victim" in crime reporting.

b. General Dissemination

In addition to contributing statistical and analytical materials for use in a wide variety of popular and technical publications, AoA maintains a statistical—general title of "Facts and Figures on Older Americans." Three new analyses were published: No. 6 State Trends, 1950–1970; No. 7 Income and Poverty in 1972—Advance Report; No. 8 Poverty by State and Ethnic Group (1969).

A revision of a 1966 pamphlet of charts and accompanying analyses, entitled "New Facts About Older Americans" was printed.

During the year, an informal statistical memorandum series was developed to supplement the more formal "Facts and Figures on Older Americans" series. Subjects covered through the end of 1973 included:

(1) Older Persons of Spanish Origin.
(2) BLS Retired Couple Budget.
(3) Authorizations in H.R. 15657 (92d Congress bill to amend the Older Americans Act, etc.).
(4) Utilization of Short-Stay (General Hospitals), 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 (Supplement #2).

(11) Cumulative Impact of Inflation.
(12) Unofficial Estimates of State Older Populations.
(13) Organization of the Senate Special Committee.
(14) Newspaper Report on "Senility."
(15) Religious Organization Position on "Euthanasia."
(16) Alcoholism Among Older Persons.
(17) Surgery in Episodes in Short-Stay Hospitals.
(18) Summary and Legislative History of 1972 Social Security Amendments.
(19) Definition and Use of Standard Metropolitan Statistical Area (SMSA).
(20) Health Status and Care of the Older Population in 1971.
(21) State Population Aged 60+ and 65+, 1971 and 1972.
(22) Marriages of Older Persons in 1968.
(23) Enrollment of Older Persons in Independent Private Health Insurance Plans, 1971.
(24) Ethnic (National) Origin of the Population.
(25) Projections of the Population to the Year 2000.
(26) BLS Retired Couples Budget, Autumn 1972, Supplement #3.
(27) Centenarians Receiving Social Security Cash Benefit Payments, June 1973.

c. Services to State Agencies

During 1973, a flow of information to the State agencies on aging transmitted especially useful statistical or analytical materials and resource materials (on a State basis) providing National trend data to assist in the preparation of State estimates.

Maintenance of "State Data Books" in the State agencies was continued. The tables in the Data Books were analyzed for the specific source of the data. A cross-reference file was established so that the arrival of publications containing necessary data automatically triggers the preparation of revised or new tables. Additional search and follow-up efforts permitted preparation of a large number of replacement pages containing newer data for duplication and transmittal to the State agencies.

d. Special Technical Assistance

AoA 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 came from public agencies at the Federal, State, and local level, and from private organizations concerned with the elderly.

A large number of requests was received from House and Senate legislative committees considering the 1973 Older Americans Comprehensive Services Amendments. Included were analyses of definitions and specific provisions contained in the new legislation, including the concept of "area" and age concentration in cities and counties, etc., and the purposes and impacts of State allotment formulas.

A considerable amount of data and technical assistance was provided to the Senate Special Committee on Aging and the Task Force on Aging of the House Republican Conference.

Other special staff services provided during 1973 as indicated:

—Involvement with other Federal agencies in developing preliminary data bases in preparation for implementation of the new National Clearinghouse on Aging, established by Title II of the 1973 Older Americans Act Amendments.
—Evaluation of experimental social indicators studies in regard to their prospective utility for aging-related service programs.
—Assistance to other Federal agencies in preparing responses to the Domestic Council request for financial commitments for aging programs in relation to the FY 1973 survey of Federal Outlays in Aging.
—Active participation in and presentation of data for a number of conferences.
(1) Workshop of State Public Welfare Research and Statistics Officials.
(2) Career Development for Professionals in Mental Health of the Aged.
(3) First Annual Fordham University (N.Y.C.) Institute on Gerontology.
(4) Duke University Conference on Successful Aging.

e. Expansion Activities

Almost immediately following the enactment of the 1973 amendments to the Older Americans Act, AoA initiated actions looking toward the expansion of its

information and data collection and dissemination responsibilities as envisioned in the legislation.

A contract was executed with an outside management agency to query users and potential users about their data needs, to begin the collection and indexing of such data, to design a system for maintaining an information and data book, and for storage, retrieval, and dissemination. Launching of the expanded operation within AoA is scheduled for early 1974. Initially, the focus will be on providing data for AoA's staff charged with planning, evaluation, and program responsibility. The data to be collected is initially limited to the low-income and impaired, non-institutionalized elderly, two target groups defined in AoA objectives. Subsequently, the data program will be expanded to cover the entire older population and to provide more detailed data to State and Area agencies and to other organizations in the field.

2. INFORMATION

The combined responsibilities of preparing for the establishment of the National Clearinghouse on Aging and responding to a vastly increased number of inquiries from Congress, public and private agencies and the general public regarding the new Titles III and VII programs, heavily engaged AoA in information activities throughout 1973.

a. Senior Citizens Month

"Older Americans in Action" was selected as the theme for Senior Citizens Month, May 1973. AoA prepared and distributed 75,000 large and 75,000 small posters based on this theme, and distributed 75,000 copies of a Presidential proclamation designating May as Senior Citizens Month. For the second time since May was first named Senior Citizen Month nationally in 1963, a television spot was prepared, distributed nationally, and widely used. It contained the name and address of each agency on aging in each State where it was distributed and used.

b. Film on Aging

During the year, a 16 mm., color and sound film—"Don't Stop the Music"—was produced, largely from film segments remaining from the films made for the White House Conference on Aging multi-media presentation. "Don't Stop the Music" challenges the negative stereotypes of older people by showing them in effective and creative action.

Prints of the film will be available from Regional Offices, State Agencies on Aging, and the National Audiovisual Center of the General Services Administration in Washington, D.C.

c. Major Publications

Nine issues of the AoA magazine Aging were published in 1973. Early in the year more than 200,000 copies of the booklet, "To Find the Way to Services in Your Community," were prepared and distributed in response to inquiries evoked by a public service TV announcement. A Spanish language version is now being printed.

The Guide to Effective Project Operations: The Nutrition Program for the Elderly was also translated into Spanish, printed, and distributed to States requesting it for the use of project personnel.

The Government of the Netherlands requested and was granted permission to reprint in Dutch the AoA publication "The Fitness Challenge in the Later Years".

In addition to fact sheets on the titles of the Older Americans Comprehensive Services Amendments of 1973, other publications produced in 1973 included:

Partnership for Older Americans, giving examples of programs in which Federal, State, local agencies, national organizations, or older people themselves are cooperating to help older people.

New Facts About Older Americans, an eight-page statistical folder.

Project Helping Wheels, a report on an AoA research and demonstration project in Raleigh, North Carolina, with "how-to" suggestions.

A Selected Annotated Bibliography of Nutrition and Aging.

Basic Concepts of Aging (revised).

Reaching Out and The Resource File, the first two of a series of manuals on information and referral.

Work Study Program in Social Gerontology, a revision of A Plan to Span.

AoA Catalog of Films on Aging.

Fact Sheet: Alternatives to Institutionalization.

Fact Sheet: Centenarians Receiving Cash Social Security Benefits, June 1973.

Fact Sheet: Employment and Volunteer Opportunities for Older People (revised).

In addition, information assistance was provided to a number of media contacts, including several with television stations and others with the following associations or publications: United Press International, the National Observer, Journal of Home Economics, Reader's Digest, Washington Post, Cleveland Plain Dealer, Baltimore Sun, McGraw Hill, Local Government Funding Report, Food Management, Journal of Psychiatry, Woman's Day, Wall Street Journal, National Restaurant News, Philadelphia Inquirer, Democrat Chronical, and Christian Science Monitor.

3. PUBLIC INQUIRIES AND PUBLICATIONS DISTRIBUTION

Forerunners of the Administration on Aging began to respond to requests for information and program guidance in the emerging field of aging almost a quarter of a century ago. Today, AoA receives scores of letters, telephone calls, and office visits weekly from persons seeking information about program operations, sources of support, publications, services available for older persons, and guidance in developing services for them. Inquiries directly related to AoA-supported programs are handled by the program units, all others by the clearinghouse. Something on the order of 2,600 response letters were prepared by the public inquiries staff during 1973 and approximately 250,000 publications were mailed to individuals and organizations who requested them.

4. INFORMATION AND REFERRAL

A requirement of the 1973 amendments is that all older Americans must have reasonably convenient access to information and referral to needed services. A new AoA staff member began to study existing I and R services and to assemble information that will be useful in providing technical assistance to State and Area Agencies. Valuable knowledge was being drawn during 1973 from an AoA-supported network demonstration project operated in 14 communities by the Wisconsin Division on Aging with guidance from Inter-Study of Minneapolis. During the year, AoA issued nine publications on different aspects of I and R services and distributed them to State Agencies on Aging. Several jurisdictions were reported to be experimenting with or tooling up for Statewide programs.

F. THE FEDERAL COUNCIL ON THE AGING

Another major development resulting from the signing of the 1973 Amendments to the Older Americans Act is the new Federal Council on the Aging.

The 1965 Act established an Advisory Committee on Older Americans to advise the Secretary of Health, Education, and Welfare. The 1973 amendments withdrew statutory authorization of that Committee, but established a Presidentially appointed Federal Council on the Aging with significantly broader responsibilities. Council membership consists of representatives of older Americans, national organizations with an interest in aging, business, labor, and the general public.

The Federal Council on the Aging has a clear mandate to serve as the national focal point for all advocacy efforts on behalf of the elderly and to channel and direct these activities to have maximum impact on the aging-related policies and programs of the Federal government. In such capacity, the Federal Council on the Aging performs the following functions:

(1) Advises and assists the President on matters relating to the special needs of older Americans;

(2) provides and conducts public forums and hearings, conferences, workshops and other meetings to obtain information, and to discuss and publicize the problems and needs of the aging;

(3) reviews and evaluates Federal policies, programs and activities regarding the aging for the purpose of appraising their value and their impact on the lives of older Americans;

(4) acts as a spokesman on behalf of the elderly by making recommendations to the President, to the Secretary and the Commissioner, and to the Congress with respect to Federal policies, programs and activities regarding the aging;

(5) informs the public about the problems and needs of the aging, working through the National Clearinghouse on Aging, by collecting and disseminating information, conducting or commissioning studies, and by issuing publications and reports;

(6) assists the Commissioner in making annual appraisals of manpower needs in the field of aging.

G. Office of Planning and Evaluation

AoA's Office of Planning and Evaluation (OPE) was established during 1973. Its establishment brought increased internal emphasis on the functions explicit in the Office title, and combined in a single organizational unit, primary agency responsibility for the functions of planning and evaluation and legislative and policy analysis.

Among its specific responsibilities, the office:

(a) Serves as the focal point in the Administration on Aging for forward (5-year) planning, policy analysis, and evaluation.

(b) Compiles the Administration on Aging forward plan, with appropriate input from other AoA units.

(c) Conducts policy analyses of a wide range of basic program issues affecting the Administration on Aging or programs for the aging.

(d) Prepares annual AoA reports to the President and the Congress.

(e) Develops Administration on Aging legislative proposals.

(f) Identifies policy issues in proposed legislation affecting the elderly.

(g) Develops reports on pending legislation as requested by the Department.

(i) Obtains information on State legislation on aging, and periodically publishes such information, as well as information for the States on new legislation.

(j) Works with States and regional offices to develop model State legislation.

(k) Develops and implements an annual evaluation plan for the Administration on aging.

(l) Prepares program evaluation guidelines for use by State and area agencies on aging.

(m) Provides secretariat and principal analytical support services to the Federal Council on the Aging.[1]

(n) Provides principal staff support for the Federal Interdepartmental Working Group of the Cabinet-level Domestic Council Committee on Aging.

(o) Monitors follow through by Federal agencies on implementation of commitments made in the Administration's response to the recommendations of the White House Conference on Aging and the Post White House Conference Board.

In the following is a more detailed summary, by functional area, of the major OPE initiatives during 1973.

1. PLANNING

During 1973, OPE's major planning activities included the development of long-range planning guidance on AoA activity between fiscal year 1975 and fiscal year 1980. Preliminary plans were offered to guide AoA in carrying out the objectives of the Older Americans Comprehensive Services Amendments of 1973 and enhancing the status of the agency as the Federal focal point on aging.

Planning staff has also participated in the on-going review of Title IV, Research and Demonstration grants, relative to their implications for short and long-term planning in aging.

2. LEGISLATIVE AND POLICY ANALYSIS

Throughout the year, there has geen an on-going, in-house analysis of major issues related to the conduct of programs under Titles III, IV, and VII of the Older Americans Act, as amended. Included in this on-going analysis has been review of current AoA program implications for the 1974 and 1975 legislative cycles. Also included have been analyses of the implications of current Departmental initiatives, including decentralization of program responsibilities to

[1] See Section G for report on 1973 activities of the Federal Council on the Aging.

Regional offices and units of government at the State and local level, and the development of allied services legislation.

Implementation of the provisions of the Social Security Amendments of 1972 (H.R. 1) involved OPE in on-going analyses of issues relative to the Supplemental Security Income Program, social service activities under Title I, X, XIV, XVI, including proposed changes in regulations for the conduct of social service programs, Food Stamps and the food commodity programs, and health care and services under Medicare and Medicaid. The passage of the Rehabilitation Act of 1973 precipitated an OPE review of the implications of that legislation for the elderly.

During the year, the Office also published "A Summary of Selected Legislative Proposals Affecting Older Americans" covering 92d Congress proposals and an "Index of Legislation" covering legislative proposals of the 93d Congress.

Also initiated during 1973 was a staff study on the status of social and health services definitions. The in-house study has indicated the need for uniform definitions of services, development of national standards for the measurement of the delivery of such services, and consequent movement toward more meaningful assessment of program progress.

An intensive, ongoing analysis of the effects of the energy shortage was begun late in the year and is to continue throughout 1974. Federal plans and regulations for ameliorating the energy crisis are being reviewed and commented upon for their effect on the elderly in general and the conduct of the program of the Administration on Aging in particular.

3. EVALUATION

OPE developed a plan for AoA-sponsored evaluation activities during the 1974 fiscal year. Stressed in this plan has been the need for information on the elderly and services to the elderly at the national, regional, State, area, and project levels. The evaluation plan and the program evaluation guidelines relate to the overall effectiveness of AoA policies and programs and to their impact on the aging population rather than to evaluation of individual grantee management performance.

To implement the evaluation plan, OPE had, by the end of 1973:

(a) Begun the development of a methodology for a 5 year longitudinal evaluation of the Title VII, Nutrition Program. The evaluation study will attempt to measure the impact of the program in terms of its effect on the health status, nutritional status, isolation, life satisfaction, longevity, and institutionalization of the participants.

(b) Continued in its efforts to develop an Older Americans status and needs assessment survey for use by State agencies. The survey tool is to be tested in March 1974.

(c) Let a contract to develop the first portion of an AoA data base. The contractor has begun to collect statistical data on two of AoA's target groups, the low-income and the impaired, noninstitutionalized elderly, and to devise a data organization method to retrieve information by data item. This system will be expandable to include data on other groups which will be acquired under future contracts.

(d) Funded a project with the Census Use Study Group, Bureau of the Census, to develop a system for State and area agencies to collect census and other data. This system will enable the agencies to locate and define elderly with special needs or characteristics. The demonstration system is to be developed in a State and area setting, namely Nebraska and Omaha.

During the year, a previously-funded evaluation of the AoA traineeship grant program was completed. The evaluation study surveyed 17 schools which had received AoA training grant support. Under the study, a mail survey of all past traineeship grant recipients was conducted. The major purpose of the study was to determine if the traineeship grants awarded to students assisted in attracting them to the field of aging both in their study program and in subsequent work. Study results reveal that approximately 92 percent of the trainee respondents indicated that the AoA grant was a deciding or influential factor in their decision to pursue a degree with an aging specialty. The study also found that 63.2 percent of the former traineeship grant recipients were currently working in jobs dealing primarily or partly with the elderly or concerns of the aged.

ITEM 3. DEPARTMENT OF AGRICULTURE

MARCH 25, 1974.

DEAR MR. CHAIRMAN: The enclosed summary of major activities on aging during 1973 and our follow-up efforts for 1974 are transmitted herewith.

If we can assist you further, please do not hesitate to contact Clyde W. Fisk.

Sincerely,

JOSEPH R. WRIGHT, Jr.,
Assistant Secretary for Administration.

[Enclosure]

ECONOMIC RESEARCH SERVICE

The Economic Research Service is engaged in a continuing study of older Americans in Appalachia. A portion of the research is incorporated in the book entitled *Neglected Older Americans* (C. C. Thomas, publisher). In the chapter headed "Perspectives on the Older American in a Rural Setting," forthcoming articles will be entitled "Age Group, Health and Attitudes" which will appear in an issue of *The Gerontologist*; and "Generation and Perceptions of Old Age: Urban-Rural Comparison" to be published by C. C. Thomas.

FARMERS HOME ADMINISTRATION

The Farmers Home Administration, a rural credit agency, makes loans for farm programs and housing. They also make loans to public and non-profit groups to benefit communities and counties. Examples of such loans are those made for water and waste disposal systems and recreational areas. The elderly living in these areas share fully in the benefits of the programs.

ACTIVITIES OF THE U.S. DEPARTMENT OF AGRICULTURE TO HELP OLDER AMERICANS

FOOD AND NUTRITION SERVICE

FOOD STAMP PROGRAM

This program enables low-income households to buy more food of greater variety to improve their diets. Participants purchase food coupons in amounts based on family size and net monthly income and receive a large value in food stamps. These food coupons can then be spent like money in participating food stores.

The 1973 amendments to the Food Stamp Act included changes that benefit the elderly and other participants. Food coupon allotments are to be adjusted twice a year instead of once a year to reflect changes in the cost of the Economy Food Plan on which the Food Stamp Program is based. The first such adjustment was made on January 1, 1974, to reflect August 1973 food prices.

Another temporary amendment permits those receiving payments under the Supplemental Security Income Program to continue participating in the Food Stamp Program unless they live in one of the States that is providing the bonus value of food coupons in cash. These States are New York, California, Massachusetts, Wisconsin and the aged and blind in Nevada.

In the 1973 amendments, the Congress took additional steps:

—Mandated a nationwide Food Stamp Program by June 30, 1974, in all political jurisdictions including Puerto Rico, Guam and the Virgin Islands unless a State can demonstrate that such a step is impracticable.

—Imported foods and garden seeds and plants to produce food for human consumption may now be purchased with food stamps.

—Food coupons may be used by elderly recipients for meals prepared by senior citizens centers, apartment buildings occupied primarily by the elderly and other facilities that offer meals to the elderly during special hours set aside for them.

PROJECT FIND

Although this national outreach campaign ended late in 1972, the results overlapped into the following year in the form of closer relationships between community individuals and organizations interested in helping the elderly. Red

Cross, for instance, reports that Project FIND increased the awareness of their chapters of the needs of the elderly and thus have emphasized an ongoing effort to meet those needs such as availing volunteers to nursing homes, visiting the elderly at home and cooperating in local Meals on Wheels Programs.

To further assist in the nutrition education of senior citizens, the Food and Nutrition Service has available a cookbook entitled, "Cooking for Two," which is printed in large, easy-to-read text. The cookbook provides menu ideas, helpful hints on planning and serving meals for one- and two-person households in addition to information on foods needed to maintain health.

Food distribution program.—About one-fourth of the nation's 3,129 counties and independent cities still distributed USDA-donated foods to low-income households in Calendar Year 1973. By year's end, the number of such areas had declined to 679 because of transfers to the Food Stamp Program. Provisions in Public Law 93–86, enacted September 14, 1973, will result in replacement of virtually all remaining food distribution areas with the Food Stamp Program by June 30, 1974.

During 1973, the Drive to Serve Program continued to provide a delivery system in several areas of the country for elderly and handicapped recipients of donated foods. This program, initiated in 1971 to assist eligible households whose members are unable to travel to food distribution centers, is a cooperative effort of USDA, adult public service groups, student volunteers, and State and local welfare agencies. With the transition to a nationwide Food Stamp Program, it is likely that volunteers in Drive to Serve will find ways to channel their services into other outreach activities for the elderly.

In addition to food help given to needy households, selected foods were made available by USDA to public and private nonprofit institutions, including senior citizens' centers, "meals-on-wheels" programs, and other charitable organizations which provide food service for needy persons. Nutrition programs for the elderly conducted under title VII of the Older Americans Act of 1965 was established in 1973 as a separate category of eligible recipient agency under Federal regulations for food distribution. Unlike charitable institutions, these programs may receive available donated foods without regard to the individual need of elderly participants.

EXTENSION SERVICE AGING PROGRAMS IN 1973

The Extension Service increased its educational program efforts with Older Americans in 1973. It also continued to build upon and expand programs which were initiated in 1972. Included in its expansion were health consumer information programs, money management, food and nutrition, housing, clothing, food safety, and food buying and preservation.

New programs in 1973 included the funding made available from local sources for Extension to recruit, train, and supervise aides to work with the elderly. Two aides in Jefferson Davis County, Mississippi, work with senior citizens on a one-to-one basis. Sometimes they're helping them understand a communication received in the mail; sometimes they're providing transportation to the doctor, drugstore, etc. Sometimes they're helping them work with the Farmers Home Administration to obtain a loan to build a new house. Michigan has two aides who were funded by local sources and Extension employs, trains, and supervises their work with Older Americans.

Another new program thrust in 1973 was that Extension State staffs are conducting workshops for professionals who are working with senior citizens. The objectives have been to help professionals understand the problems, interests, and concerns of older people and learn how to conduct programs that will help them.

Another new dimension in late 1973 was for Extension to make others aware of the Supplemental Security Income program and its benefits.

Both the professional staffs and the volunteer Extension Homemakers Council members (550,000 in 41 States) have conducted programs that will *Help Older Americans Stay In Their Own Homes Longer.* Below are examples of how the above is being accomplished:

SERVICES

Sixteen counties in South Carolina reported that they provided services for 4,136 elderly people. Some of the activities performed were, sent cards to them

on special occasions, visited in their homes and furnished transportation for visits to doctors and grocery stores.

Lexington County, South Carolina, reported that 1,016 visits were made to shut-in elderly people and transportation was provided for 34 persons.

Delaware

"New Age For Old Age" was the title of Delaware's aging project which included visiting elderly and providing transportation as well as taught crafts at Senior Citizen Centers and assisted with the "Meals on Wheels" program. Special emphasis was placed on providing transportation and recognition for the elderly to the Extension Homemaker Club meetings.

Florida

In Florida, a club whose members are retired people who live in a 168 room apartment building for the elderly has a regular program of visiting sick residents, making cancer dressings and providing food for them. They provided Christmas dinner for 38 people. An Extension Homemaker Club member in Columbia County, Florida, assumed the organizer role for the County Council on Aging. She had participated in the Gerontology Conference at the University of Florida and this was a result of that conference.

Virginia

York County, Virginia, reported that the Extension Homemaker Club members with other community organizations had located 1,300 elderly through conducting a survey. They obtained names and addresses so they could provide them with information regarding benefits and services as they are announced by agencies and organizations.

North Carolina

Many senior citizens, individuals, and groups were adopted by clubs. Educational and recreational programs were held for these individuals.

In one county, senior citizens carry ID cards that permit them to receive a discount from local merchants. Eligibility is based on age and income. This special project was carried out by an Extension homemaker.

Twenty percent of the counties reported having either a "DIAL HELP" program or a system indicating the senior citizen was *ill or well.*

Montana

In Stillwater County, a senior citizens center was formed. A building was renovated with volunteer help. The center was furnished by contributions of dishes, chairs, tables, etc. Following an open house in May 1972, the center is open daily, Monday to Saturday: 10 a.m. to 5 p.m. and on Sunday: 2 p.m. to 5 p.m. The number registered are 273 with an average daily attendance of 20 and average dinner attendance is 75. All volunteer workers.

EDUCATIONAL PROGRAMS

Florida

In one county, all the clubs had lessons on "The Aging Process" and "The Role of Grandparents in Today's Society" for 400 people. "Making A Will" was the title of the program that reached 400 people.

Another county had a club program on the "Second Forty Years" that reached over 300 people.

Many new residents are coming to Florida annually. Most are senior citizens. Florida Extension Homemaker Club members realize that they are adjusting to leaving friends and families, they have less work and more free time. EHC's are involving these new residents in programs on Florida's Tax program, Wills, Housing, Health, Crafts, Food and Nutrition, Self-Defense, Defensive Driving Courses, and Recreational activities.

Maryland

One of Washington County's club's programs was "Plan for Living the Rest of Your Life."

Mississippi

Club programs on aging included, "Adjusting Life Styles," "Diets and Menus for the Elderly," "Legal Matters," "Better Retirement," "Job Opportunities," and "Social Security."

North Dakota

One project that the North Dakota Homemakers are very proud of is their program on "Wills and Estate Planning," and "Life Insurance." Over 15,000 people received education on "Wills and Estates." Over 13,500 received education on "Life Insurance." It was explained what to look for in an insurance policy, the four basic policies of life insurance, pointers for policyholders, when to buy and where to keep the policy.

Concerning the "Wills and Estate Planning," a large percentage of the clubs had local attorneys speak to their groups. It was explained—who shall leave a will, requirements for a valid will, and when there is no will. Steps in making a will, what is probate, how long is a will good were also explained. The roles of the executor were explained whether it be an individual or trust company. Every county in North Dakota participated in these programs.

ITEM 4. ATOMIC ENERGY COMMISSION

JANUARY 30, 1974.

DEAR SENATOR CHURCH: I am pleased to submit the enclosed report in response to your letter of December 21, 1973, requesting information for inclusion in the forthcoming annual report of the Senate Special Committee on Aging.

The Atomic Energy Commission continues to sponsor long-term research on the late somatic effects of ionizing radiation in human and animal populations. This research is an essential element in the agency's overall effort to make meaningful cost-risk-benefit analyses of nuclear power production and alternative modes of energy generation. As discussed in the enclosure, observations extending over most if not all, of the lifespan are made during the course of experiments on late radiation effects in human and animal populations. Such observations yield valuable information on the aging process as it occurs naturally and under conditions of superimposed radiation stress. Supporting this type of programmatic activity is a modest program of basic research aimed at developing mechanistic and conceptual insights into the aging process.

During the fiscal year 1973, $3.1 million were allocated for the support of research directly related to aging in human and animal systems, while funding of studies indirectly related to aging and lifespan shortening totaled $9.2 million. Scientists at 17 AEC-owned (on-site) facilities and 12 off-site contractor laboratories participated in the overall effort. The projected levels of funding for fiscal year 1974 are $4 million and $9.9 million, respectively, for research in the directly related and indirectly related categories. Research identified as indirectly related to aging includes studies in animal species where observations on control (unirradiated) populations provide information on age-related biological changes and causes of death. The classification of appropriate studies into two categories of aging research represents a new method of reporting adopted to provide a better view of the total AEC-supported effort in the field of aging research. Because of this procedural change, the total level of support identified with aging research in fiscal year 1973 is substantially higher than that reported a year ago (for fiscal year 1972). Actual increases in support for individual projects were modest.

I hope the information provided will prove helpful and that you will call on me if I may be of further assistance.

Sincerely,

JAMES L. LIVERMAN,
Director, Division of Biomedical and Environmental Research.

[Enclosure]

PROGRAM OF RESEARCH ON AGING SPONSORED BY THE ATOMIC ENERGY COMMISSION

The Atomic Energy Commission sponsors a continuing broad-based biological research program to appraise the health and environmental impact of nuclear energy technology. Presently, a major goal is to evaluate the long-term risks associated with low level exposure of large populations to radioactive materials associated with production of energy from nuclear fission, encompassing the entire fuel cycle from the mining of uranium ore to the final disposal of the waste generated by the utilization of this energy source.

It is essential in this regard to evaluate the latent somatic and genetic risks involved in the continuous lifetime exposure of man, as well as experimental animals which have short and long lifespans, to low levels of ionizing radiation. Thus, the research program permits an evaluation of the disease states that occur as the animals age normally, and under the stress of an imposed radiation dose. In this context, unstressed animals contribute valuable information about normal aging processes, and the stressed animals uncover the weak links in normal physiology that lead to premature aging or lifespan shortening which is due primarily to specific types of malignant diseases.

These basic and applied studies complement the types of biomedical research activities sponsored by the National Institute of Child Health and Human Development and other units of the U.S. Public Health Service.

Since there is a strong emphasis to identify the cause of death or lifespan shortening, much information is generated about the sequence of cellular and physiological changes that lead up to fatal diseases. Data of this sort are important to any realistic attempt to prevent or overcome the disease states associated with the normal process of senescence or those specific malignancies that result from the added stress of radiation exposure. Since malignant diseases are an important part of the complications associated with an aging population, much of the research effort is completely relevant to geriatric problems.

Because the AEC program is aimed at generation of data applicable to man, it includes long-term epidemiological followup of a number of human populations exposed to moderate and low levels of radiations.

Long-Term Human Studies

Long-term epidemiological studies of four major exposed populations are in progress at the present time.

The oldest study involves the survivors of the Japanese populations exposed at Hiroshima and Nagasaki. Over 100,000 Japanese nationals are being observed routinely for changes in body function, as well as disease states that contribute to morbidity, mortality and possible lifespan shortening. The most heavily irradiated groups are being evaluated in terms of connective tissue changes in skin and blood vessels which may correlate with lifespan shortening or normal aging. To date, there is no indication of lifespan reduction that is not attributable to malignant diseases. This program is a joint effort between the U.S. National Academy of Sciences and the Japanese National Institute of Health and is conducted by the Atomic Bomb Casualty Commission.

A much smaller human population from the Marshall Islands accidently exposed to radioactive fallout from a thermonuclear weapon test has been followed since 1954 by a group of investigators at the Brookhaven National Laboratory. The exposed group consists of about 200 Marshallese who were exposed to moderate external radiation doses as well as high internal exposure to the thyroid gland from radioactive iodine. Although a substantial elevation of thyroid abnormalities has been noted and corrected by hormonal or surgical treatment, there is no evidence to date of premature aging in the exposed individuals as compared to unexposed cohorts in spite of careful application of the most pertinent criteria of the aging process.

The largest prospective study consists of over 170,000 individuals who have been employed for part of their lives by contractors at major AEC production and laboratory facilities. Health records on a large number of these people will be available as well as morbidity and mortality information. An appropriate control population is also being followed. This is a joint project conducted by epidemiological investigators at the University of Pittsburgh and the contractors who operate the AEC facilities. While the study seeks primarily to determine if very low dose radiation exposure correlates with lifespan shortening or latent diseases, valuable information should accrue on the normal aging processes in a sizeable population of humans who have spent most of their lives under similar environmental conditions.

A much smaller human population is being systematically followed by investigators at the Argonne National Laboratory. These are primarily individuals who occupationally or otherwise have accumulated a high body burden of radium and thus have an exceptional level of this radioactive element in their skeletons. Their lifetime exposure to abnormal levels of radioactivity makes them valuable

subjects for radiobiological research as well as for studies of the senescent processes. Such local radiation stress to a localized tissue, the bone, might well serve as a model for understanding some of the specific degenerative processes associated with normal aging.

Lifetime Studies on Long-Lived Mammals

While it is important to take every available opportunity to evaluate human data for direct estimation of adverse effects of radiation in man, it is frankly admitted by most biomedical investigators that studies with experimental mammals will have to provide most of the quantitative information required for predictions for the human population. Until sufficient comparative animal research is completed, it will be necessary to examine degenerative and malignant diseases in both long- and short-lived species of mammals. The beagle dog has been the model long-lived mammal in the AEC experimental program for more than 20 years. Under carefully controlled experimental conditions, this mammal lives one-fifth as long as man. At the University of Utah, Argonne National Laboratory, University of California at Davis, the Lovelace Foundation, and Pacific Northwest Laboratory, more than 5000 beagle dogs have lived out their normal lifespan under experimental observation. These animals have been followed with periodic clinical examination unsurpassed by that received by any controlled human population. Geriatric research, per se, has not been a specified mission of the AEC; nevertheless, these aging animals, radiation stressed for the most part, represent a resource unanticipated by most agencies involved in "aging research" per se. It seems certain that the information carefully derived from stressed and, more importantly, unstressed beagle populations will be valuable to all agencies.

Long-Term Research With Other Species

Major emphasis has been placed on small rodents for large-scale animal experiments to determine risk estimates for low doses of ionizing radiation. While these species are short-lived (lifespan 2–6 years), there is little or no evidence that normal aging is not a simple function of lifespan. The use of a variety of inbred mouse strains has contributed to understanding of the genetic factors involved in senescence as well as specific diseases that account for radiation-induced lifespan reduction. These studies have been conducted primarily at the Argonne National Laboratory and the Oak Ridge National Laboratory. Presently, investigators at the Argonne National Laboratory are involved in an assessment of late somatic effects of heavy ionizing particulate radiation (neutrons) which may demonstrate the role of nonspecific diseases in lifespan shortening.

The present thorough effort to define in great detail the pathological states that lead to death and morbidity should contribute handsomely to a better understanding of the development of latent somatic damage which contributes to aging and death under environmental stress.

Basic Research on Aging

The AEC has never fostered a major research effort on the most fundamental aspects of the "aging process." Nevertheless, somewhat over $1 million was spent during the past year for programs at the Argonne National Laboratory and the Oak Ridge National Laboratory for such research efforts. These studies obviously complement the larger effort of the National Institute of Child Health and Human Development. In addition, we have always sponsored small research efforts on aging in various university departments.

Studies of Age-Related Diseases

It is important to mention that two other areas in the AEC Biomedical Research Program contribute toward diagnosis and treatment of diseases of the aging or aged. These include clinical and experimental research at Brookhaven National Laboratory on hypertension and senile osteoparosis as well as Parkinson's disease, and a sizeable effort in a number of laboratories to develop radioisotopic techniques for the early diagnosis of a variety of human diseases.

ITEM 5. CIVIL SERVICE COMMISSION

JANUARY 16, 1974.

DEAR MR. CHAIRMAN: This is in response to your letter of December 21, 1973, requesting a summary of Civil Service Commission activities in 1973 which affect older Americans, and planned activities for 1974.

The activities of this Commission are not directed at a specific age group. As the agency with overall responsibility for the Federal personnel system, we do, however, deal with older Americans employed by the Federal Government or interested in employment with the Government and with former employees entitled to benefits as a result of Federal employment. We recognize that as the Nation's largest employer our actions with respect to these groups of older Americans may influence the actions of other employers.

The following summarizes our major activities in 1973.

EMPLOYMENT OF OLDER PEOPLE

It has long been the policy of the Federal service to provide older workers with fair and full consideration for employment and advancement. This policy was reaffirmed by President Nixon's memorandum to heads of departments and agencies dated September 13, 1972. This Presidential message was called to the attention of each agency director of personnel in a memorandum from the Executive Director of the Civil Service Commission dated September 22, 1972. Agencies were advised that activities and practices affecting employment of older workers would be reviewed during overall evaluations of agency equal employment opportunity programs.

Further, we respond to specific allegations of discrimination based on age, recommend appropriate corrective action, and followup as needed to assure that the policy of nondiscrimination is adhered to. These review and response activities continued during 1973 and will continue in the future.

We provide technical assistance to congressional committees with regard to proposed legislation to amend the Age Discrimination in Employment Act of 1967 to cover Federal employees.

PRERETIREMENT COUNSELING

For more than 4 years the Civil Service Commission has actively encouraged Federal agencies to establish preretirement counseling programs. For an even longer period we have assisted agencies in establishing such programs, and we frequently supply a speaker for program sessions. In addition, through interagency training activities, we periodically sponsor programs to train agency personnel to develop and maintain preretirement counseling programs for their own agencies.

BROADENING FREEDOM TO CHOOSE TIME TO RETIRE

Implementation of Public Law 92–39 (enacted June 12, 1973). This amendment to the Civil Service Retirement Act permits an employee who is at least age 50 and has completed at least 20 years of service or at any age after at least 25 years of service to retire optionally when the employing agency is undergoing a major reduction in force. Thus, older career employees in agencies which the Commission determines are undergoing major reductions have the alternative of filing for optional retirement regardless of the manner in which the reduction would otherwise affect them.

Implementation of Public Law 93–136 (enacted October 24, 1973). This amendment guarantees that any employee who retires after a cost-of-living increase becomes effective will receive as much annuity as would have been paid if the employee had retired on the day before that increase was effective. This amendment serves to eliminate the financial pressure to retire immediately preceding the effective date of a cost-of-living increase irrespective of other considerations.

CIVIL SERVICE ANNUITANTS

In 1973, the Commission completed a survey of annuitant income for 1972. Similar studies were conducted with respect to annuitant income in 1957 and 1964. The purpose of the survey was to develop facts on total income, income by source, and relationships between total income, civil service annuity amount,

years of service, average salary, and years retired. A report describing the findings from this survey was issued in June 1973 and will be helpful, both to the Commission and to the Congress, in considering proposed legislation affecting civil service retirees and survivor annuitants.

Pursuant to 5 U.S.C. 8340(b), annuities payable under the Civil Service Retirement Act were increased by 6.1 percent effective July 1, 1973 and by 5.5 percent effective January 1, 1974. This section of the retirement law authorizes the automatic adjustment of civil service annuities when the cost of living nationwide rises at least 3 percent and stays up for 3 consecutive months. This serves to maintain the purchasing power of civil service annuities.

The Commission initiated an unclaimed benefits project to identify and locate former Federal employees over age 62 with at least $50 in the retirement fund in order to determine their possible entitlement to benefits under the Civil Service Retirement Act.

PROJECT SSI ALERT

We pledged our assistance to the Social Security Administration in communicating information to civil service annuitants about Supplemental Security Income benefits provided by Public Law 93-66 (enacted July 9, 1973). There is a need to publicize the availability of these benefits offered under the Social Security program so that those eligible may apply.

During 1974, we will continue to seek to assure fair consideration of job applicants and treatment of employees, regardless of age, and to provide services and assistance related to administration of the Civil Service Retirement System.

I hope this information will be helpful in the preparation of the Special Committee on Aging's 1973 report. If we can provide any additional assistance, please let me know.

Sincerely yours,

THOMAS A. TINSLEY,
Director.

ITEM 6. DEPARTMENT OF COMMERCE

JANUARY 30, 1974.

Dear MR. CHAIRMAN: The enclosed narrative summarizes Department of Commerce activities during 1973 which directly affect older Americans. This report is submitted in response to your request of December 21, 1973.

Sincerely,

FREDERICK B. DENTS,
Secretary of Commerce.

[Enclosure]

PROGRAMS FOR THE AGING—1973

STATISTICAL RESEARCH AND DATA

During the year the Bureau of the Census concluded its publication program of the 1970 Census of Population and Housing. Almost all of the reports for each of the States and for the entire Nation contained detailed information on the numbers and geographic distribution of older Americans. Included was information on their demographic, social, and economic characteristics. Statistical data on older Americans, as well as the total population, are also contained in the 39 Volume II, Subject Reports, of the 1970 Census of Population on such subjects as ethnic groups, migration, fertility, marriage and living arrangements, education, employment, occupation and industry, and income. Through the Current Population Reports of the Bureau of the Census, updated information is presented on older Americans and on the total population. One recent Current Population Report has been published specifically on older Americans. This report is entitled "Some Demographic Aspects of Aging in the United States." In 1974 the Bureau of the Census plans to publish a report specifically on the social and economic characteristics of older Americans.

An official of the Bureau of the Census was appointed to the Interdepartmental Task Force for Research in Aging. The function of the group is to propose immediate action and plan future steps for the coordination of Federal research and related activities which concern our older population.

The Bureau, through its Census Use Study project, is initiating an applied research program for the Administration on Aging. This prototype effort will

focus on the use of Census and local data for planning and coordinating activities at the State and area (sub-State) levels. The prototype sites for these activities will be Nebraska and Omaha respectively.

The Bureau also acts as collecting agency for the National Center for Health Statistics (NCHS) and the Social Security Administration (SSA) and gathers data in support of some of their programs. Following is a brief description of the surveys involved. In regard to the health related programs, to the extent that health considerations bear most seriously upon older persons, such data are of special significances for the aged.

Title and sponsor	*Description*
Health interview survey (HIS) (NCHS)	Data are collected from a total of 42,000 households throughout the year. The information collected is related to acute and chronic health conditions, disability, doctor and dentist visits, and other health related items.
Hospital discharge survey (HDS) (NCHS)	Data are abstracted from sample medical records of patients discharged from 467 short-stay hospitals throughout the United States as part of the national health survey program.
Supplemental income survey (SIS) (SSA)	This survey will measure the effects of the supplemental security income program by obtaining data from a sample of 20,000 individuals before program implementation and resurveying these persons a year later. Information is being collected on work history, health characteristics, housing and community characteristics, and income.
Current medicare survey (CMS) (SSA)	Data are collected from a monthly sample of approximately 5,000 medicare recipients and 2,000 persons receiving disability insurance payments. The purpose is to provide SSA with current national estimates on the extent, kinds, and cost of medical services. This is provided on a continuing basis for analysis of the Medicare Insurance Program.
Longitudinal retirement history survey (LRH) (SSA)	This survey is a continuation of a longitudinal study of approximately 11,000 respondents concerning their work history, health, and financial status, and their preparations, plans, and attitudes toward retirement. Data will be collected every other year over a projected 10-year period.
Master facility inventory (MFI) (NCHS)	This survey is conducted every 2 years to maintain an updated file of all facilities in the United States which provide medical, nursing, personal, or custodial care. This file is used as a sampling frame for surveys conducted by NCHS.
Health examination survey (HES) (NCHS)	Personal interviews are conducted in about 10,000 households in selected areas or "stands" to obtain a listing of household members, along with some demographic data, from which a sample of about 12,500 persons are examined for nutritional deficiencies and a sub-sample of 2,500 receive a more detailed clinical examination by PHS medical teams.

Consumer Affairs and Safety

Many older Americans feel the need to reduce household expenditures wherever they can. The National Bureau of Standards, through its building technology program, has provided two documents (circulation of several million) that illustrate how energy consumption in the home (and hence utility bills)

may be reduced. These documents are, respectively, "7 Ways to Reduce Fuel Consumption in Household Heating" and "11 Ways to Reduce Energy Consumption and Increase Comfort in Household Cooling." Household appliances such as air conditioners, ranges, water heaters, and refrigerators have traditionally been designed and marketed with little regard for their power consumption. In cooperation with other concerned agencies, the Department of Commerce, through the National Bureau of Standards, has established a program for the voluntary labeling of household appliances and equipment. This program, which was announced in the Federal Register of October 26, 1973, will permit comparisons by purchasers of the efficiency of various brands of the same type of appliance. Working closely with industry trade associations, NBS has established a basis for uniform labeling for all brands of home air conditioners. This labeling procedure will be published in the Federal Register within the next 30 days. NBS will extend this work to cover water heaters, refrigerators, and freezers.

Older Americans are too often the victims of an accident in the home such as a fall or an injury from a consumer product. In 1973 NBS strengthened its program to deal with safety in buildings and safety with consumer products. Studies currently underway include those of the safety of stairs, ramps, landings, balconies, and floors; establishing just how appliances actually cause injuries so that safer appliances can be developed; studies of the hazards of sharp edges and points: and safety aspects of furniture, matches, glass, carbonated drink bottles, and space heaters.

Since older Americans figure strongly in fall statistics, they are likely to benefit from NBS research on improvements in hip prosthesis. The NBS study has involved laboratory and operating room investigations of the commercial polymeric bone cement used for the attachment operation. The medical profession has been aided by the documented procedures for the optimum use of this material.

Working with industry and testing laboratories, NBS has underway a program aimed at saving lives in fires through advance warning of danger provided by smoke detector units. Program objectives are to improve smoke detection technology and develop performance standards for detectors and standard test methods for their evaluation. Outputs of this program to date have been used by the Department of Housing and Urban Development in standards for multifamily housing, housing for the elderly, and nursing homes.

Private Pension Plans

As the result of a joint effort with the Social Security Administration and the Department of Labor and Treasury, administrative proposals were developed to provide increased assurance that workers actually receive the benefits called for in private pension plans. Under the proposals, pension benefits would be required as a condition of employment; employees would be given a greater role in the management of their pension plans; and the transferability of pension benefits would be increased so that an employee would not lose accumulated benefits with a change in jobs.

The Department's primary participation in this effort was directed toward resolving some of the technical difficulties encountered before practical and workable proposals could be made. Without solutions to the problems, a Federal requirement with respect to pension plans could actually work to the detriment of employees by causing their employers to abandon or minimize currently existing pension plans or by discouraging the adoption of plans where none now exist.

National Health Insurance System

During the year the Department continued its work with the Department of Health, Education, and Welfare on the development of a national health insurance system. In the process of guaranteeing all Americans access to adequate medical care, changes would be made in the Medicare and Medicaid programs. We have had particular involvement in the issue of mandatory employer plans which would take over a larger share of the total cost of medical care. Such plans would do much to assure both that persons start their older years in the best possible physical condition and that a sound medical care delivery system evolves to assure the aged of receiving good quality care.

ITEM 7. DEPARTMENT OF DEFENSE

JANUARY 18, 1974.

DEAR MR. CHAIRMAN: This is in reply to your letter of December 21, 1973, requesting information summarizing the Defense Department's major activities on aging during 1973.

One of the major activities on aging in which the Department of Defense is involved is our comprehensive retirement planning program for civilian personnel. This program has been established as an integral part of the overall 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 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 preretirement counseling, but includes such features as trial retirement and gradual retirement options for interested employees.

Our preretirement 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. The trial retirement option entails 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 the gradual retirement option, employees either retire optionally with immediate re-employment 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.

The Department of Defense continues to actively cooperate with ACTION, the new Federal agency that combines several citizen service programs into a unified effort devoted to helping people help themselves. Through our representation on ACTION's Interagency Coordinating and Liaison Committee for Federal Employee Voluntarism, we assisted in developing and initiating 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 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 special health and placement programs which are designed to provide maximum practicable assistance to employees who have limitations resulting from physical or mental disabilities or those associated with increasing age. The special health programs generally include such items as glaucoma screening, electrocardiogram testing, diabetes screening, blood pressure checks, etc., and are usually administered free of charge to employees over age 40.

As a result of the President's memorandum in late 1972 reaffirming our commitment to the Federal Government's longstanding 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 followup efforts will include emphasis on program improvements and augmentation.

We appreciate the efforts of the Senate Special Committee on Aging, and we hope that the above information will be helpful to you.

Sincerely,

CARL W. CLEWLOW,
Deputy Assistant Secretary of Defense
(Civilian Personnel Policy).

ITEM 8. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

DEAR MR. CHAIRMAN: I am pleased to provide a statement summarizing major activities relating to older Americans carried out by the Department of Housing and Urban Development during 1973, as well as some follow-up efforts in 1974.

Particular note should be made of the fact that the President, in his announcement of the results of the housing study in September 1973, designated the elderly poor as the priority recipients under the anticipated new direct cash assistance program.

I would like to assure the Committee that my Department remains firm in its commitment to respond to the needs of our older Americans, and I look forward to working with you and your colleagues in the Congress in this regard.

Sincerely yours,

JAMES T. LYNN,
Secretary.

[Enclosure]

I. PRESIDENT'S RECOMMENDATIONS TO CONGRESS ON NATIONAL HOUSING POLICY

For the Department of Housing and Urban Development, calendar year 1973 was a period of evaluation of what had been done under various HUD programs.

Three HUD subsidized housing programs had been used to provide housing designed for the elderly—the Section 236 program, rent supplements and the low rent public housing program. Prior to 1973, however, there had been a succession of reports and findings revealing evidences of abuse and misuse of these programs by builders and sponsors and improper actions by some HUD staff.

On January 5, 1973, former Secretary Romney directed all Regional Administrators, Area Office Directors and Insuring Office Directors to suspend new approvals under the subsidized programs. The President subsequently directed that the Department undertake a sweeping study of Federal housing policy.

A task force was formed comprising more than 100 analysts in HUD from several other Departments of the government and from the academic community. Advice and suggestions were obtained from knowledgeable staff and Members of Congress and from 125 private organizations. Over 500 documents and letters received from the public were analyzed and incorporated into the review.

The studies of the programs were completed, a report was issued, and on September 19, 1973, the President transmitted his recommendations to Congress, including both legislative and administrative proposals, which are designed to assist all, including older Americans, in securing a decent living environment. The recommendations may be grouped as follows:

—Ease the present tight mortgage credit situation.
—Make it easier for homeowners—urban and rural—to obtain mortgages over the longer term.
—Assist low-income families to obtain decent housing.
—Improve the community environment for housing.
—Assure equal opportunity for all Americans seeking housing.

A. EASING THE PRESENT TIGHT MORTGAGE CREDIT SITUATION

The President is seeking to moderate the tight mortgage situation by:

—*Authorizing the Federal Home Loan Bank Board to approve a program of "forward Commitments".* This authority will cover $2.5 billion in loan commitments enabling savings and loan institutions to make mortgage commitments now for future use.

—*Underwriting a portion of mortgage interest rates under the "Tandem Plan",* by which the Government National Mortgage Association will commit to buy up to $3 billion (increased to a total of $6.2 billion by the President in 1974) of residential mortgages carrying interest rates somewhat lower than current interest rates. This will result in substantial new construction starts.

—*Requesting Congress to authorize increases in the permissable mortgage amounts of FHA loans,* which will make the advantages of FHA available to larger numbers of homebuyers who cannot obtain credit conventionally in the current mortgage market.

B. MAKING IT EASIER FOR HOMEBUYERS—URBAN AND RURAL—TO OBTAIN MORTGAGES

The President is seeking legislation which would update and improve the existing laws governing mortgage credit by:

—*Permitting homebuyers to pay market interest rates on FHA and VA insured mortgages*, eliminating discount points which have often had the effect of increasing some prices and interest paid.

—*Authorizing on an experimental basis more flexible repayment plans in FHA insured mortgages*, which could permit young families and others to make smaller payments in the earlier years of the mortgage and larger payments later when their incomes are higher.

—*Establishing a mortgage interest tax credit up to 3½%*, which will encourage more financial institutions to invest in residential mortgages. The greater the proportion of a portfolio represented by mortgages, the higher the tax credit on all the mortgages in the portfolio. With at least 70% of portfolios in mortgages the tax credit on the interest those mortgages earn would be 3½% or the equivalent, at current interest levels, of an additional interest yield of over one-half of 1%.

—*Authorizing more flexible interest rates, and longer repayment terms for purchasers of mobile homes*, which should have the effect of significantly reducing financing costs on these loans.

C. ASSISTING LOW-INCOME FAMILIES TO OBTAIN DECENT HOUSING

The President is seeking to make decent housing available for all low-income families without the housing "project" stigma, the loss of freedom of choice and the inordinately high costs of current programs by:

—*Identifying direct cash assistance as the most promising approach to help such families*, thereby maximizing the use of existing decent housing and freedom of choice and reducing costs per family as compared with subsidizing construction of new housing for low-income families.

—*Taking the further action needed to complete development and evaluation of an operational program*, under which the Federal government would provide assistance to qualified recipients so that they can choose their own decent homes on the private market. Such assistance would be scaled to make up the difference between what a family could afford on its own for housing and the cost of decent housing in that area. In view of the substantial resources required for full implementation—estimated at between $8–$11 billion annually (as against $34 billion annually for reaching all eligible families under current programs)—such a program would have to be phased in over a number of years, with the first stage—probably covering the elderly.

—*Undertaking a limited program for additional subsidized housing* in FY 1975 with 300,000 units to be provided under a revised (section 23) Public Housing Leasing Program, 225,000 of which will be newly constructed. The current program is being modified administratively to the extent possible so as to maximize the freedom of choice principle inherent in direct cash assistance, significantly expand the role of private owners who will own, operate and lease units and permit tenants to make rental payments directly to a private landlord. Other changes would be made upon enactment of new legislative authority by the Congress.

—*Improving the operation of our existing public housing projects*, by correcting the present situation in which:

—incentive for effective management is lacking,

—rent income ratios are subject to a ceiling but not a floor,

—income is unrealistically defined,

—the responsibilities of localities, and the Federal government are inappropriately allocated, and

—the entire Federal operating subsidy system needs both a structural revision as well as the injection of more funds, and the FY 1975 budget proposes to increase the level to $400 million.

D. IMPROVING THE COMMUNITY ENVIRONMENT FOR HOUSING

In April 1973 the President submitted the Better Communities Act to the Congress which would provide $2.3 billion of shared revenues to cities, urban counties and states for community development activities, beginning July 1, 1974.

In addition, the President is continuing to seek a better living environment in our communities through encouraging preservation of our neighborhoods and improving planning and management of our communities by :

—*Requesting the Congress to improve HUD's home improvement loan program,* so that borrowers can have readier access to longer term home improvement loans, longer payment periods and higher mortgage amounts.

—*Reinstating the 312 Rehabilitation Loan Program for fiscal year 1974,* making available $60 million in rehabilitation loans with priority being given to communities which need these loans to complete present projects or where complementary local rehabilitation efforts have already been launched, to further assist in the transition to the Better Communities Act in fiscal year 1975.

—*Developing a partnership of local government, local financial institutions and the citizens of the neighborhoods involved along with the Federal government* so that Federal mortgage insurance in older, declining areas will be provided as part of a total approach which is necessary to arrest decline in such neighborhoods.

—*Requesting Congressional enactment of the Responsive Governments Act,* under which $110 million was requested for fiscal year 1974 to help State and local governments develop reliable, useful information on their problems and opportunities, develop and analyze alternative policies and approaches, achieve a stronger management capability and evaluate the results of their efforts.

E. Assuring Equal Opportunity for all Americans Seeking Housing

In 1964 and 1968 the Congress enacted far reaching legislation to insure that all Americans had equal access to obtain the housing of their choice. In 1971 the President detailed the policies of the Administration regarding the implementation of that legislation. The President reaffirmed his 1971 commitment to vigorously pursue a wide range of efforts to enforce fair housing and equal opportunity laws. Existing legislation does not expressly prohibit the restriction of mortgage credit availability on the ground that the applicant's financial resources, which would otherwise have been adequate, are insufficient because the applicant is a woman. The President is seeking to correct this situation through cooperative action with the Congress.

II. SUBSIDIZED HOUSING PROGRAMS FOR THE ELDERLY

Although the suspension of new approvals under the subsidy programs was in effect throughout most of calendar year 1973, previous commitments were honored and a modified approach to the Section 23 Leased Public Housing program was initiated. As the President's September 19, 1973 Housing Message indicated, during the period in which a new approach is being developed, there will be a continuing need to provide housing for some low income families. It is recognized that in some areas of the country there will simply not be a sufficient supply of housing for the foreseeable future. Therefore, the President proposed that the Federal Government continue to assist in providing a limited amount of construction for low income housing—though this approach would be used sparingly.

During the remainder of fiscal year 1974, the Department of Housing and Urban Development will continue to process subsidy applications under the Section 236 and Rent Supplement programs for units which had moved most of the way through the application process by January 5, 1973. In addition, the Department will process applications under those programs in cases where bona fide commitments had been made prior to the suspension. Approval under the suspended programs in calendar year 1973 amounted to nearly 28,000 elderly units due to commitments made prior to the suspension. A total of 480,573 units of subsidized housing have been approved from the inception of the various programs through calendar year 1973. A total of 329,679 of these units have been completed and are under management.

The Section 23 Leased Public Housing program, under which new and existing housing is leased for low income families, can be administered in a way which carries out some of the principles of direct cash assistance. Accordingly, the President lifted the suspension of January 5 with respect to this program and directed the Secretary of Housing and Urban Development to take administrative steps to eliminate any abuses from the program and to bring it into line as closely as possible with the direct cash assistance approach.

The Section 23 leasing program operates under the provision of the Housing Act of 1937, as amended, and under existing law operates through local housing authorities or certain State housing agencies. Its provisions make possible a leasing program under which suitable living arrangements can be sought by the poor and rent assistance obtained through the local authority (or State housing agency). The Section 23 Leased Public Housing program will provide significant assistance for the elderly and handicapped.

Revised regulations for the program, in order to permit the program to be administered in a way which carries out some of the principles of direct cash assistance, have been published for comment in the Federal Register in early 1974 and the comments received on the proposed regulations will be carefully evaluated prior to issuance of final regulations. At this time, HUD anticipates permitting assistance for generally not more than 20 percent of the units in each building; however, up to 100 percent of the units may be assisted in the case of elderly or handicapped tenants. Furthermore, it is anticipated that HUD will earmark about 25 percent of the contract authority for units for use by the elderly and handicapped.

Some of the most helpful sponsors of projects for the elderly and handicapped have been religious and other non-profit organizations which provide not only the managerial skill to develop and operate the project but also the special dedication so necessary to make these projects the kinds of homes our senior citizens deserve. In this regard, there is now under consideration a proposal whereby contract authority would be allocated to State housing agencies in accordance with Section 23. The State agencies would then work directly with non-profit sponsors as developer-owner-operators of the projects. In addition, non-profit sponsors are permitted under Section 23 to lease projects to local housing authorities as well. It is hoped that the State agencies will respond affirmatively to this proposal so that non-profit sponsors of projects for the elderly and the handicapped will continue to play, under improved programs, the role they have so ably played in the past.

In addition, in order to eliminate the many tangled problems which attend the delivery of subsidies under current construction programs, the President also recommended new legislation for construction assistance by the Federal Government. Under this approach the developer would make newly constructed units available at special rents for low income families and the government in return would pay the developer the difference between such rents and fair market rents.

The President also recommended that legislation be enacted to authorize a refundable tax credit for those low income elderly persons whose property taxes exceed five percent of their income. The proposal would also provide equivalent relief for the low income elderly individual who pays rent.

III. UNSUBSIDIZED HOUSING PROGRAMS FOR THE ELDERLY

SEC. 232—NURSING HOME AND RELATED FACILITIES MORTGAGE INSURANCE PROGRAM

The nursing home program has been of great assistance to the elderly. Approximately three quarters of the residents of nursing homes are elderly. Although the elderly have low incomes and generally could not afford nursing home attention, the medicare and medicaid programs of HEW have made it possible for the elderly to benefit from the many nursing facilities provided under the HUD Section 232 nursing home program.

The primary objective of the Section 232 Nursing Home and Related Facilities Mortgage Insurance Program is to assist and promote the construction of long-term care facilities.

During the 13-year life of the 232 program, HUD–FHA has insured the mortgages for almost 1,000 facilities (more than 100,000 beds) totaling nearly one billion dollars.

Although this program costs the taxpayers virtually nothing, it returns to local, State and Federal government agencies taxes in excess of $25 million annually.

The 232 program was added to the National Housing Act by the 1959 amendments. The program established the first set of nursing home construction standards. These were continually revised to meet advanced technology and subsequently served as the model for State construction standards throughout the Nation.

In 1971 the President demonstrated the interest and concern of the Nation when he mandated an eight-point program to improve the care and services received by the almost two million long-term care patients. HEW was assigned the responsibility to upgrade the care and services received by the patients, and HUD's responsibility to provide financial assistance for the development of the safe physical environment was reemphasized.

Program activity:

Since 1960 there has been a steady growth in the 232 program. By the end of 1962, 98 projects had been insured and there were 278 applications in the pipeline.

By the end of 1973, the 232 program had passed the one-billion dollar mark for commitments. HUD–FHA field offices had received 1,529 applications, issued 1,172 commitments, and insured $918,194,427 in mortgages for 969 facilities housing more than 100,000 beds. By then 87 mortgages totaling $44,141,511 had been paid in full, and only 16 had been acquired for an overall foreclosure rate of 1.6%. Only seven facilities remain in the HUD inventory.

Since 1971, HUD has been attempting to increase the versatility of the Section 232 program. To meet the growing medically recognized need for rehabilitation facilities for alcoholics and drug addicts, for the mentally ill, and those recuperating from illness, injury or other increasingly expensive bed care, applications for such facilities have been accepted where accompanied by a certificate of need and assurance of inspection and licensure from the State health agency. In 1972, the maximum amortization term was extended from 20 to 40 years to be more compatible with HUD housing programs for the elderly and handicapped and facilitate development of the campus complex.

On December 26, 1973, Subsection (i) was added to authorize insured loans to provide fire safety equipment for nursing homes and intermediate care facilities to meet the requirements for participation in the Medicare and Medicaid programs. HUD and HEW are coordinating efforts to make Section 232(i) operational.

Also, since 1971, the HUD "Outreach Concept" has encouraged sponsors of long-term care facilities to make their dining, therapy and group activity facilities available to residents of the community at cost to prevent premature and unnecessary institutionalization where applicable. With advance planning and minimal expansion, the medical, health, dietary and rehabilitation capabilities of the long-term care facility (with its emphasis on geriatric medicine and gerontology) can be the natural center for health, nutritious meal service, activity, therapy and day care service programs for the elderly living alone, with working spouses or younger family members.

SECTION 231—HOUSING FOR THE ELDERLY FOR PROJECT MORTGAGE INSURANCE

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% of replacement cost in the case of profit-motivated sponsors and up to 100% of replacement cost for non-profit sponsors. The current maximum interest rate is 8¼%, plus ½ of one per cent mortgage insurance premium.

In 1973, activity under the Section 231 program continued at a modest level. Prospects for the future appear uncertain at this time because of new legislation proposed by this Administration which is now under consideration by the Congress. However, the decline of activity in recent years under this program suggests a growing need and market for unsubsidized housing for the elderly will have developed when sponsors once again turn their attention to the housing needs of those who do not require financial assistance.

PROPOSED LEGISLATION RELATING TO SECTIONS 231 AND 232

The Administration has proposed legislation which will combine all multifamily insurance programs under one section, thus eliminating the separate

identity of Section 231. The new section can be used to provide mortgage insurance for housing for the elderly as presently provided under Section 231.

The proposed legislation also eliminates Section 232 by combining it with a new provision for mortgage insurance for care facilities. Insurance of nursing homes, as provided presently under Section 232, would be possible under this new provision.

Existing projects would continue to be serviced under existing regulations. Action on these provisions depends upon enactment of the legislation by Congress.

IV. EXPERIMENTAL HOUSING ALLOWANCE PROGRAM

The Department of Housing and Urban Development has launched a new research program, the Experimental Housing Allowance Program, to evaluate the concept of channeling Federal assistance directly to families in need of housing instead of through organizations in the business of providing housing.

The experimental program will produce information upon which to base key decisions: first, the decision as to whether the *direct* assistance approach is in fact a tenable one; and decisions as to *how* and in *what form* the direct assistance can best be administered.

Under the concept to be tested, a housing allowance will be made available to families in need. The families may canvass the market to select housing of their choice. Because the payments are made to a family instead of being attached to a specific housing unit, they will follow a family as it moves from one unit to another so long as its income is so low as to require assistance. This direct form of housing assistance is expected to expand a family's housing choice and provide for its free movement in the housing market.

This research effort is designed to determine whether it is desirable to add a new element to the present range of housing subsidy programs or to adjust existing programs. The present system of subsidies tied exclusively to specific housing units may not be the most effective means of providing for the shelter needs of America's lower income families. This system has some weaknesses in terms of both cost and equity, and there are difficulties in administering programs that identify particular buildings or houses as "poor people's housing." The housing allowance, which permits the recipient to shop for housing throughout the market, and permits a degree of anonymity, appears potentially to have significant advantages.

The program, authorized by the Housing Act of 1970, is being conducted as a part of the Housing Assistance Research Program under the direction of the Assistant Secretary for Policy Development and Research.

The direct assistance approach is not a new idea. What is new is the idea of a detailed, methodical research effort to determine the values—pro and con—of such an approach and to test alternative administrative mechanisms for initiating a full-scale operating program.

At this point there is no unanimity of professional opinion with respect to the value of this type of assistance. Will recipients of assistance be able to find decent housing? Will they really take advantage of the increased mobility offered by the assistance? Should a large investment be made in a program that will not add directly to the Nation's stock of new housing? Will landlords rehabilitate substandard properties and increase maintenance? Will allowances have mainly an inflationary price effect on the housing market? There are opinions on both sides of these and other crucial questions. But there are no definitive answers. The experimental program is designed to provide answers gained from observation and analysis of actual tests.

A full-scale, relatively long-term research effort as a prelude to the possible enactment of legislation or establishment of a social program is a new approach in our housing programs. In the past, new programs and policies generally were put into effect with little or no preparatory testing to disclose potential problems and to give an objective basis for determining the kinds of administrative arrangements that are needed to make new programs and policies work. This time the concept will be pre-tested.

The Experimental Housing Allowance Program has three main elements:

A *Demand Experiment* that will analyze the use of direct housing assistance by some 1,000 families is being run in the Pittsburgh, Pa., and Phoenix, Arizona, metropolitan areas. Different forms of direct assistance will be tested, and the ways in which they are used by the participating families will be measured and compared. This consumer-oriented experiment involves relatively small numbers of families living in relatively large communities. For this reason, it

cannot and is not intended to assess the true market effects of this kind of assistance.

A *Supply Experiment* will provide information on the market effects of a full-scale operating housing allowance program. To accomplish this, a full-scale operating program will be "replicated" in two metropolitan areas of approximately 200,000–250,000 population. Agreements have been reached to conduct the Experimental Housing Allowance Program in Green Bay, Wisconsin and discussions are underway in Saginaw, Michigan. Some 4,000 to 8,000 families will participate in each location. Analysis will center on such critical questions as: Will rents become inflated? Will housing rehabilitation and maintenance increase or decline? Will investment be stimulated? Will families exercise their broadened choices to attain decent housing in suitable neighborhoods?

Administrative Agency Experiments will be conducted in up to eight locations to evaluate the effectiveness of various agencies in administering housing assistance. Administering the Experimental Housing Allowance Program will be two local housing authorities; Salem, Oregon and one other to be selected; two metropolitan area county government agencies, Jacksonville, Florida, (Department of Housing and Urban Development, Consolidated City of Jacksonville) and San Bernardino County, California, (San Bernardino County Government); two State community development agencies, Springfield, Massachusetts (Massachusetts Department of Community Affairs) and Peoria, Illinois (Illinois Department of Local Government); and two welfare agencies yet to be selected. Up to 900 families will receive direct housing assistance in each area.

These three elements, which are the basis for a full analysis of an operating housing allowance program, form HUD's Experimental Housing Allowance Program. In total, twelve experiments among these three elements, will be run throughout the United States, aiding approximately 18,000–20,000 families and providing a wide variety of urban conditions in which to test housing allowances.

Although these experiments were not designed to focus specifically on the problems of the elderly in the housing market, some information will be gained in the context of the analyses that were planned. Additionally, there will be relevant data available that could be specially analyzed and, in the Administrative Agency Experiment, there are plans to collect additional survey data to augment that already available within the experimental design.

The Demand Experiment, which will complete its enrollment by the end of February 1974, is designed to have a participant sample representative of the community at both sites (Phoenix, Arizona, and Pittsburgh, Pa.). It is expected that about 22% of the participants will be elderly households. The focus of the Demand Experiment is the participant family and its experiences under carefully controlled variations, and a wide variety of interviews and survey data is being collected, including information on the quality of housing and neighborhoods, participant initiative, locational choices, maintenance and rehabilitation, and cost factors. In some of the analyses planned, elderly participants will be compared with other age groups on such questions as to quality of housing, satisfaction with their homes and neighborhoods, and the degree to which they move. They will be consistently observed as a relevant subgroup throughout the experiment. Reports from the Demand Experiment are scheduled for Fall 1975 into mid-1976.

The Supply Experiment, which will begin enrollment at its first site in March 1974, will have open enrollment for income-eligible families (6,000 to 9,000 participating families at each of the two experimental sites, Green Bay, Wisconsin, and a second site to be selected.) It is expected that approximately 40% of the participants in the experiment will be elderly. Any eligible renter or owner who wishes to participate may do so, within the upper limit enrollment constraint. Further, since a high proportion of homeowners are elderly, inclusion of this group as eligible for allowance payments in the Supply Experiment will tend to insure substantial elderly representation.

Annual surveys will be made of the residents of the housing units that are chosen for study (4,000 units at each site), and exhaustive questions will be asked regarding the:

—characteristics of housing and neighborhood quality
—housing expenses
—mobility (post and pre-allowance)
—employment history of head of household
—family composition

Initial reports from this experiment will be prepared by late 1975. Since the analysis focuses on market effects rather than on the recipient families, information specific to the elderly subgroup will be obtained only peripherally in the basic experiment. Large amounts of data will be available, however, and special analyses of the elderly participants could be made if they are of interest at that point in time.

The Administrative Agency Experiment was designed to determine experimentally the most satisfactory and cost-effective administrative procedures that may be used under varying conditions in the delivery of a housing allowance program. Since one measure of a successful administrative process or function is the effect on the participant, data regarding participant attitudes, responses, and experiences are being gathered in several different contexts, including from agency record keeping, from surveys, and from in-depth participant case studies.

The final enrollment period will be completed as of March 1974, for all of the eight agencies in the AAE and we estimate that the final number of recipients across all eight sites will be approximately 5,500, with about 20% (1100) being elderly households. (The elderly sample size becomes increasingly smaller as aggregate data are divided into the eight sites, and into the smaller survey samples, and into the still smaller case study sample.)

Several reports from the AAE will be completed in 1974, and these will contain some information on the elderly subgroup. For example, the Enrollment Process report, due in August 1974, will contain information on whether or not there are age differences in participant reactions to the functions of outreach, screening, certification and enrollment. Similarly, the report on Inspection and Counseling, due in September 1974, will have information on the extent to which elderly participants attended counseling sessions and some descriptive data on the extent to which they required special counseling services. Any age-differential results, or lack of them, will also be noted in the inspection process analysis. Reports on the other administrative functions, scheduled for completion during 1975, will contain similar reports of findings by age group where relevant results are found.

A special study now underway in Jacksonville, Fla., is examining why many enrollees failed to attain participant status. It will, among other questions, attempt to determine if the age of the enrollees had any effect on their inability to find suitable standard housing. This study will be reported by the end of April 1974. The in-depth participant case studies (eight at each site) will include 17 elderly households. These case studies will be completed by early 1975.

Special Study of the Elderly (under the AAE). Since there are considerable data available in the AAE which could be profitably analyzed specifically in terms of the elderly, we are now considering a proposal from the evaluation contractor, Abt Associates, for such a special study. Abt also proposes to build up some of the smaller sample sizes presently available by conducting a special survey. This special study will stress such questions as: How the elderly recipients use their housing allowance; the ability of elderly households to shop for housing; the relationship of the housing allowance to the special needs of the elderly; and the delineation of an appropriate outreach, application and enrollment system for the elderly. It is expected that this study will be conducted, although details as to the exact scope have yet to be established. The study will be carried out during the summer months of 1974 and the results should be available in early fall.

V. ADDITIONAL HUD-SPONSORED STUDIES RELATED TO THE ELDERLY

In 1973, the Department initiated the design of three research proposals of relevance to the housing problems of the elderly and handicapped. The first two respond to specific recommendations formulated by the White House Conference on Aging. The third, while it is specifically directed towards the problems of the handicapped, will also have implications for elderly housing. Contractors for these research proposals will be selected in early 1974.

Property tax relief.—An evaluation of existing and proposed property tax relief measures to assist elderly homeowners which will examine the effectiveness of all such measures at the national and State level, and of a sample of such measures at the local level. Recommendations will be made on revising the

schemes if necessary, on expanding their applicability if they prove worthwhile, or on implementing a uniformly applied, nationwide system of property tax relief for elderly homeowners.

Home maintenance and repair assistance.—This study will look at the size of the home maintenance and repair problems facing the elderly, will examine the causes of such problems (including, but not limited to the problem of limited incomes), and will examine any existing solutions to these problems. It will then suggest a feasible solution(s) to the problem, taking into consideration services necessary and costs involved.

New ANSI standard.—The existing American National Standards Institute Standard for Making Buildings and Facilities Accessible to and Usable by the Handicapped is the basis for Public Law 90–480, and for many State and local codes. However, it does not address the problems of designing accessible and usable dwelling units or exterior sites. The new Standard will be expanded to include these and will also update the design features of the existing Standard. The information will also be supplied to FHA for inclusion in the Minimum Property Standards, especially in PG 46 for housing for the elderly and handicapped.

Two additional research projects were underway in 1973 and a follow-up study is planned for another recently completed research project.

Housing listening post.—The Listening Post is a volunteer staffed Housing Information and Referral Service which serves the entire State of Washington through the use of toll-free telephone lines. About half of the volunteer staff is composed of elderly persons. Since the service began in June 1973, over 4,000 cases have been handled by the volunteers, with a satisfactory referral rate of about 70%.

Personal alarm system.—The Sacramento Breakthrough building for the elderly is the demonstration site for a personal alarm system which consists of a small pen-like device which the elderly carry on their person and activate in case of accident or other emergency. Initial results showed the device workable, although the elderly had some initial reluctance to wearing or carrying it because they felt it was a stigma which identified them as in need of special help. As it helped to save lives, however, its acceptance grew. The demonstration has now been expanded to include a second neighboring building so the cost of the 24 hour monitoring of the system may be reduced.

Highland Heights.—This is a public housing project for the handicapped in Fall River, Massachusetts, which is occupied largely by the elderly handicapped. A study of the facility showed that residence there can replace institutionalization and increase independent living at a cost much lower than that of institutionalization because of the special design of the building and the large variety of medical and social supportive services available on the premises. A follow-up study will increase the study sample to determine if persons with different types and degrees of disabilities benefit differentially from residence in the building. This will lead to more rational tenant selection criteria for such facilities.

VI. HOUSING MANAGEMENT ACTIVITIES RELATED TO ELDERLY HOUSING

A primary focus of HUD's activities related to elderly persons has been through safety and security. The elderly have continually been identified as the most victimized persons residing in public housing and other HUD-assisted housing projects. For the elderly, the problems of security are quite real, quite extensive and of high priority. It should be noted that in attempting to improve the total living environment of elderly residents, HUD has left the purely physical realm of housing environment and attempted to support other agencies and offices in their attempts to improve the social, psychological and economic status of the elderly living in HUD-assisted housing.

A. Security

The National Security Conference, held in September, 1973, was actively concerned with the security problems of all HUD-assisted housing. The elderly, however, became a major concern and the center of several discussions relating to improved security for housing projects. The following recommendations relating to elderly persons emerged:

—Elderly should be given a choice of living in projects designed exclusively for the elderly or projects for both elderly and non-elderly. However, careful selection of families for all units is needed to attain a secure environment for all tenants.
—While conversion of existing buildings to accommodate elderly tenants is advocated, changes in regulations to allow non-related elderly to share larger apartments which would reduce conversion costs and improve security should also be considered.
—Initial responsibility for security falls on the tenant. Management should be responsible for implementing and maintaining various security measures, while police are to function in apprehension and providing technical assistance.
—Sources for funding should be identified and control over the allocation should be given to local authorities supported by guidelines from the Federal government. The principal sources for security funds are the Law Enforcement Assistance Administration and Revenue Sharing monies.
—Further research and development in the area of security for the elderly is needed.

Prior to the September conference, security specialists were designated in both Regional and Area offices. Security personnel, housing authority officials, HUD staff and residents were invited to participate in the seven security workshops sponsored by HUD as a follow-up to the National Conference. The workshops, focusing on planning security programs for individual local housing authorities, acted as a medium for information exchange with residents and LHA staff discussing their security problems and the relative effectiveness of their programs.

At the Security workshops, HUD staff, meeting with several LHA's attempted to determine how extensive the security problem was and whether the elderly as a group were overly victimized. It was found that smaller housing authorities did not have serious problems with elderly and mixed family occupancy, and that perhaps the problem was peculiar only to large inner-city authorities.

In order to determine more specifically which housing authorities are plagued by victimization of the elderly, a questionnaire is now being drafted which will determine extent, location and incidence of criminal activity against the elderly and the cost of conversion and/or relocating elderly units into all elderly buildings or projects.

The Security Handbook, presently being printed for distribution, is a 100 page composite of HUD's security concepts to date. It concerns itself with the role of management in a step-by-step manner of how to organize and implement a security program. One section, "Special Considerations Regarding Elderly Residents", concerns itself with problems and opportunities regarding elderly, the question of separation of elderly and families, security for exclusive elderly projects and security for elderly residents of family projects.

B. Reducing Fire Hazards

This past year, the 36 page "HUD-Assisted Housing Fire Safety Handbook" which was widely distributed to Local Housing Authorities, managers, and HUD's Regional and Area Offices, contains specific recommendations on how to reduce the incidence of fires and how to handle the situation should a fire occur. A section is devoted specifically to Elderly and Handicapped in explaining special methods or techniques of fire safety of which they should be aware.

C. Training Programs

The National Center for Housing Management:

Established in April 1972 with HUD financing, the Center functions to produce a curriculum and to conduct training sessions which improve management capabilities. The staffing for the elderly component of the Center started in February, 1973, and was completed in May of that year. Its objective is to increase the number of housing managers qualified and trained to meet the needs of the elderly in housing.

Curriculum especially designed for elderly housing management has been assembled, written and refined by NCHM curriculum staff, assisted by outside experts in the field of gerontology and housing.

Under a recent HEW grant the Center is presently conducting a training program for resident managers of elderly housing.

D. Nutrition Program

The Community Services Branch in Housing Management has been actively engaged in support of the Nutrition Program for the Elderly since August, 1973, when, under the Older Americans Act, the $100-million allocation for Nutrition Projects to be initiated by the end of calendar year 1973 was announced. A *Notice* to local housing authorities, Regional Administrators, and Directors of Area and Insuring Offices was distributed; and Community Services Advisors in the ten Regional offices were directly conferred with, to stimulate action by local housing authorities with suitable facilities for Nutrition Projects or for applying for grants to administer them.

The total number of local housing authorities or other HUD-assisted housing for the elderly now participating in the Nutrition Program has not yet been compiled; some Nutrition Projects are still getting underway. Those housing authorities known to be participants are either grantees or site-suppliers—mostly the latter.

Missouri, for example, reports 14 local housing authorities supplying sites, with the program operating a joint effort with local non-profit groups. As an example of a primary contractor (grantee), the local housing authority in Somersworth, N.H., is administering a project that embraces two other localities, and is using RSVP participants and the site space as its 10% contribution to total cost.

HUD is maintaining contact with the Administration on Aging, to gain benefits of the AoA Nutrition Project reports from the field, as well as to pursue ways in which collaboration of mutual benefit can be undertaken, HUD-housed elderly residents represent a focus on Nutrition Program Participants; many public housing projects have suitable community space for serving meals; and other low-income elderly in the community can be brought to the public housing site for the congregate meal service.

E. Supplemental Security Income

Supplemental Security Income provisions of the Social Security Amendments of 1972 (P.L. 92-603) gave elderly, blind, and disabled residents of HUD-assisted housing—those not on welfare as well as those on public assistance—a boost in payments beginning January, 1974. The aim: to give the low-income elderly, or blind or handicapped individual an income of at least $140 a month and $210 if a couple.

To aid in spreading the word about these increases, HUD issued an "alert" to local housing authorities and managers of other HUD-assisted housing for low-income elderly, and to HUD field offices in October, 1973. It was pointed out that Community Services Advisors and similar personnel could be called on for technical assistance to process applications of elderly residents with District Social Security Offices. Informational materials on the working of the program were secured from SSI headquarters in Baltimore and distributed to HUD field personnel.

A second issuance by HUD to the field, dated February 5, 1974, contained the findings of a survey by the Nashville, Tennessee Housing Authority that showed that a total of 867 elderly and disabled residents would automatically be converted by the local welfare department on January 1, 1974, to receive the initial base benefits. In addition, approximately 600 non-welfare elderly were determined to be eligible for the benefits. The average increase in the incomes of both groups is approximately $30 to $35 a month.

Benefits to management of the housing for the elderly, in terms of potential added rent revenue, thus were also evidenced, since rent changes can be 25 per cent of income. Therefore, in the same HUD issuance, warning was given that adjustments in rents of elderly tenants to reflect the SSI-prompted increases were to be made only at the time of the regularly scheduled re-examination of family income and eligibility; at other times provided for by adopted management policy; or as specified in the tenant lease.

ITEM 9. DEPARTMENT OF THE INTERIOR

FEBRUARY 5, 1974.

DEAR MR. CHAIRMAN: This is in reply to your letter of December 21, requesting a paper summarizing major activities on aging during 1973.

The Department is participating in the Retirement Advisors, Incorporated program, and for the second year interested employees within 5 years of retire-

ment eligibility are receiving informational booklets on retirement and topics relating to aging. In addition, we have employees trained in the Civil Service Retirement System at headquarters and at each field personnel office to provide individual counseling on request.

Many of our bureaus keep their retired employees informed of bureau activities through periodic newsletters. The enclosed copies of "Personnel Highlights"* from the Bureau of Land Management, is an example. Another Bureau, Sport Fisheries and Wildlife, offers a preretirement planning course, "Active Retirement: The Reward of Civil Service."* This home-study course is offered to all employees who will be eligible for retirement within the next 5 years. Two copies of the booklet are enclosed.

The Department has no definite plans for activities on aging in 1974, as of this date. We will continue to offer counseling to employees with questions regarding retirement. This counseling will be supplemented with available printed information on the Civil Service Retirement System, Social Security, retirement organizations, and the Retirement Advisors, Incorporated program.

Sincerely yours,

JOHN F. MCKUNE,
For Assistant Secretary of the Interior.

ITEM 10. DEPARTMENT OF LABOR

DEAR MR. CHAIRMAN: This is in reply to your request of December 21, 1973, asking for a summary of the Department of Labor's major activities on aging during 1973. I am enclosing a report from the Manpower Administration updating the material we submitted last year on Operation Mainstream. I am also enclosing a report from the Employment Standards Administration on its activities under the Age Discrimination in Employment Act.

In terms of future impact, the current work of the Department in the area of pension reform will also have a lasting influence on the lives and well-being of the aging. We hope and expect that legislation will be enacted in 1974 that will provide greater protection for the pensions of American workers and thereby increase the economic security of their old age.

Sincerely,

PETER J. BRENNAN,
Secretary of Labor.

[Enclosures]

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 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 has operated under title I–B of the Economic Opportunity Act of 1964, as amended. Operation Mainstream, Title I–B funds for fiscal year 1973 consisted of obligations of $58.3 million by regional office contracts with local sponsors and $22.8 million in contracts with national associations. The fiscal year 1974 funding plan is $79.7 million on the regional level and $20 million on the national level. National office Operation Mainstream consists of the five national office older worker contracts which follow the same general 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.

*Retained in committee files.

Attached is a chart of the National Office Older Worker projects with their fiscal year 1974 funding levels.

The Manpower Administration is presently in the process of phasing out the Federation of Experienced Americans as a contractor in the Operation Mainstream programs. All enrollees of the Federation of Experienced Americans Program will have been transferred to the other five National Mainstream programs by February 1, 1974. The attached table approximates the funding and slot levels of each of the five Mainstream contracts after this transfer has been effected.

During previous contracts, the primary concern of Operation Mainstream-National Older Workers programs was to place into unsubsidized jobs, which provide a community service, persons 55 years of age or older, who fit the poverty income criteria and who were chronically unemployed. In fiscal year 1974, the Manpower Administration has put greater emphasis on the placement of program enrollees into unsubsidized jobs. This will assure some turnover of enrollees in the Operation Mainstream slots, and allow other eligible people to become exposed to the program. The unsubsidized placement goal in the current contracts varies between 10 and 20 percent, depending on the primary locations of each contract (rural or urban).

The impact made by the senior community service program is immeasurable in those areas where it was placed. The purposes of the program have continued to exceed initial hopes. The purposes are: (1) To show the need for added financial support to unemployed or retired senior citizens; (2) to prove to the community the existence of another manpower pool that is dependable and reliable and (3) that with the knowledge that they are again needed and wanted, the senior citizens can overcome some of the aging problems such as fear, loneliness, and melancholy.

Sponsors	Period of performance	Approximate funding level (thousands)	Approximate slots	Proposed unsubsidized placements	Sites
National Council of Senior Citizens (NCSC)	Jan. 1–Sept. 30, 1974.	$4,655	1,986	143	34
National Council on the Aging (NCOA)	Jan. 1–Sept. 30, 1974.	2,183	1,008	84	18
National Retired Teachers Association (NRTA)	Dec. 13, 1973–Sept. 18, 1974.	3,709	1,770	171	31
National Farmers Union (Green Thumb)	Jan. 1–Sept. 30, 1974.	6,860	3,734	370	25
U.S. Forest Service	Feb. 1–Sept. 30, 1974.	1,625	785	78	[1] 50

[1] In 21 States.

A REPORT ON IMPROVEMENT AND PROTECTION OF EMPLOYMENT OPPORTUNITIES OF OLDER WORKERS

The Employment Standards Administration (ESA) in 1973 reaffirmed its determination to implement its primary objectives in the administration and enforcement of Federal labor laws, including, among others, the improvement and protection of opportunities of older workers under the Age Discrimination in Employment Act (ADEA). This law protects individuals who are at least 40 but less than 65 years old from age discrimination in most phases of employment. The stated purposes of the Act are to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; and to help employers and workers find ways of meeting problems arising from the impact of age on employment. High priority is being given to the enforcement of this law and ESA's activities are meeting with increasing success.

There are approximately 800,000 establishments employing an estimated 46 million persons that fall within the scope of the ADEA. It is not known how many of these persons are in the 40 to under 65 year age group. However, labor force data show that 37 million persons, or about 41 percent of the 89 million persons 16 years of age and older who were in the civilian labor force in September 1973 were in the 40 to under 65 year age group.

During fiscal year 1973, a total of 7,229 investigative actions were taken in 6,856 establishments; violations were disclosed in 2,933 establishments or 43 percent. Monetary damages in the amount of nearly $1.9 million were found due 1,031 individuals in 217 establishments; income was restored to 304 individuals in the amount of $662,000 in 96 establishments. Nonmonetary discriminatory practices were found in 2,716 establishments; 8,800 employees who had been discriminated against because of age were aided, i.e., hired, rehired, promoted, put into a retirement program, etc.; and 39,667 job opportunities were made available by the removal of discriminatory age barriers.

There were 1,836 instances of illegal advertising in the past fiscal year. Ads containing terms such as "between 21 and 35," "recent college graduate", "young man or woman", discriminate against older workers and are in violation of the ADEA. It is felt extremely important to eliminate discriminatory advertising since help-wanted ads are for many the gateway to employment.

Court Actions

Since the Age Discrimination in Employment Act became effective in June 1968, some 182 court actions have been commenced by the Secretary of Labor under the Act. In calendar year 1973, 46 suits were filed, and 45 cases went to adjudication in the trial courts. As of the end of 1973, 8 ADEA cases were pending in appellate courts. Five of these suits were instituted by the Secretary; the other three were employee suits. In two of the employee suits, the Secretary is participating as *amicus curiae*.

During the first few years after the Act's inception the Department of Labor's litigation efforts under ADEA, in large measure, concentrated on discriminatory newspaper advertising, and on evidentiary and related burden of proof issues. In the last year, however, the ADEA litigation program has focused in on more substantive issues involving those sections of the Act which prohibit discriminatory acts or practices in hiring, discharging, mandatory retirement, and on computation of damages. The lawsuits discussed below are typical of the kinds of cases brought by the Secretary during 1973 and highlight the issues presented to the courts.

Hiring Practices

The transportation industry is a clear example of an employer's refusal or reluctance to hire persons in the protected age group. Several major interstate bus lines, for example, refuse to hire a bus driver over age 40 regardless of what that driver's past experience and driving record show. This practice is totally inflexible and the bus companies will not bend it even to accommodate a driver who, for one reason or another, may wish to transfer to another company. The bus companies justify the age requirements on the grounds that they constitute a bona fide occupational qualification (BFOQ) reasonably necessary to the normal and safe operation of the bus. This employment practice has been challenged as a violation of ADEA and lawsuits against Trailways and Greyhound are pending in the court of Appeals for the fifth and seventh circuits, respectively. The Chicago trial court which heard the Greyhound case rejected this contention stating that the company "ha[d] not established * * * a 'factual basis' for the belief that applicants between the ages of 40 and 65 would be unable to perform the duties of [a] * * * driver." On the other hand, Trailways successfully asserted the same defense in the Federal district court of Miami. Definitive opinions by the appellate courts may well establish the principle that employment decisions cannot be made on age considerations alone unless, of course, the employment in question falls within the narrowly construed BFOQ exception, in which case the employer must show a factual basis which confirms that a younger person is needed for the job. A similar suit was brought against United Parcel Service challenging its less formalized practice of rejecting applicants in the protected age group and also challenging a provision in the company's collective bargaining agreement with the teamsters which restrict part-time employment to students.

Discharge

Discriminatory discharges may occur in a number of situations but compliance investigations, particularly of large nationwide corporations, show that reductions in force adversely impact on the older worker. The Pan American Airways case is a good example. Although the case was settled before trial, the

compliance investigation disclosed that a disproportionate number of the older workers was discharged. The company agreed to pay $250,000 in damages to 29 former employees. This represents the single largest recovery under ADEA to date and individual recoveries ranged between $1,000 and $13,500.

The Department is increasingly negotiating affirmative action programs with employers whose business practices have been investigated pursuant to ADEA. Such plans insure that qualified applicants 40 years of age and over are considered to fill job vacancies. Affirmative action plans can run the gamut from a formalized program monitored by the Department to an informal agreement by an employer or employment agency to go a step beyond eliminating restrictive words or phrases from help-wanted ads by inserting phrases such as "age open," "age is no barrier," "all ages," etc., in the ads.

During the next year the Department expects a significant increase in the number of cases filed, those decided at both the trial and appellate levels, and in the number of investigations closed by affirmative action programs.

As is the case with all measures designed to eliminate discrimination in employment, the most difficult problem encountered in enforcement of the ADEA is attempting to overcome long-standing negative attitudes on the part of employers and employment agencies with respect to the capacities of middle-aged and older workers. It is felt that in addition to solving specific problems, we also have the added effect of helping to change these attitudes.

ITEM 11. DEPARTMENT OF TRANSPORTATION

JANUARY 31, 1974.

Dear MR. CHAIRMAN: In response to your letter of December 21, 1973, I am pleased to enclose the statement summarizing the major activities of this Department in assisting older Americans during 1973.

If we can assist you further, please let us know.

Sincerely,

CLAUDE S. BRINEGAR,
Secretary of Transportation.

[Enclosure]

DEPARTMENT OF TRANSPORTATION PROGRAM OF ASSISTANCE TO THE ELDERLY—1973

I. INTRODUCTION

During 1973, the Department of Transportation carried out a variety of activities on behalf of older Americans. The following covers legislation and program activities in the area of urban, rural, air, highway, and rail transportation.

II. LEGISLATION

The Federal-Aid Highway Act of 1973 contains several provisions which augment the Department's ability to improve transportation for the elderly. The provisions which offer the greatest potential for improving transportation services for the elderly are as follows:

a. One provision, amending the Urban Mass Transportation Act, authorizes the Secretary of Transportation to make grants and loans to private nonprofit corporations and associations for the specific purpose of assisting them in meeting the special needs of elderly and handicapped persons for whom mass transportation services otherwise provided are unavailable, insufficient, or inappropriate. This is a significant enlargement of the Department's authority to help the private sector supplement public transportation services for the elderly. Criteria and procedures are being developed for implementation of this new legislation.

b. Another provision requires that State highway safety programs submitted for departmental approval must provide adequate access for the safe and convenient movement of physically handicapped persons across curbs constructed or replaced after July 1, 1976. This requirement will help the very large number of elderly who have limited mobility. The Federal Highway Administration is taking steps to implement this program through a proposed change in the highway safety program standards.

c. The statute authorizes a Rural Highway Public Transportation Demonstration Program. The Federal Highway Administration is taking steps to ensure that ways to help solve transportation problems of the rural elderly will be emphasized.

III. Program Activities

A. Urban Transportation

1. *Recently Completed Research*

Findings from a recently completed study of a rural transportation bus system in Venango County, Pa., by Clarion State College, showed that (1) costs per passenger decreased during the project; (2) benefits and revenues exceeded the costs of the system; and (3) social interaction and participation in the community increased as a result of the availability of transportation.

2. *Ongoing Research*

a. The transportation problems of the elderly is a subject being addressed by institutions funded through the Department's program of university research. One study entitled "Mobility of the Aged and Handicapped" has these objectives: (1) To establish the needs and transportation desires of the aged and those with orthopedic infirmities; (2) to establish the nature and economics of existing public transportation services; and (3) to plan a program to provide a more effective, balanced service of transportation to the subject group.

b. A second study, entitled "Problems of the Carless," is identifying and analyzing the nature, extent, and consequences of carlessness, including (1) collecting of disaggregated data on travel demands of the carless, and development of a trip priority matrix; (2) development of travel purpose opportunity models in light of alternative modes; (3) analysis of travel activity and inactivity by socioeconomic and demographic groups; and (4) evolving recommendations for improved transportation service for the carless, based on project analysis.

c. A third initiative under the University Research Program was the development of a resource paper on transportation needs of the aged and handicapped by the Upper Great Lakes University Consortium for Transportation Research. This paper will serve as a resource document in efforts to improve transportation services in the Upper Great Lakes region.

3. *Research Planned*

The Department anticipates funding three studies related to the elderly under its program of university research during 1974. The first study will address innovations in the area of demand-responsive systems such as ride sharing, taxi pooling, and taxi-oriented dial-a-ride systems. The second study will investigate the relationship between mass transit usage and fear. The third study will investigate the factors important in consumer motivation.

4. *Demonstrations*

CENTRO—The public transportation authority in Syracuse, N.Y., has received an Urban Mass Transportation Administration (UMTA) grant to test an advance reservation, flexible route service for the elderly.

5. *Capital Assistance*

a. In Connecticut, the city of Bridgeport has received an UMTA grant to assist in the construction of a new commuter rail station in the downtown area replacing the old station. The new structure will be provided with elevators, automatic doors, and ramps to facilitate the accessibility of the elderly and handicapped.

b. UMTA has provided financial assistance to the Chicago South Suburban Mass Transit District for commuter rail cars which will help to eliminate travel barriers in the cars as well as in the stations. The cars will be equipped with wider doors, thereby providing wheelchair accessibility. Ramps will be installed in the Park Forest Station and the transit district is exploring the feasibility of providing ramps for the system's remaining existing stations.

c. The Kansas City Transportation Authority, through an UMTA capital grant, has made a special effort to make its bus system more accessible to elderly and handicapped persons. The new buses will include a special grab rail at entry and exit doors; extra lighting at both the stepwell and out levels; and diagonal stripe marking on the edges of all steps.

d. The city of Kalamazoo, Mich., recently received UMTA capital assistance to purchase two 31-passenger buses to be used for a demand-responsive service for the elderly and handicapped. Both vehicles will be equipped with hydraulic lifts.

e. UMTA assisted the City of Jackson, Miss., to purchase five 16-passenger transit vehicles which will be used for a free service for the elderly and handicapped. One of these vehicles will be equipped with a hydraulic lift in order to accommodate the nonambulatory handicapped. The vehicles will operate on a demand-responsive basis and will provide either door-to-door service or feeder service to the regular fixed route system.

f. In addition to stanchions and a special grab rail for the entry door, UMTA-funded buses in Lehigh and Northampton, Pa., will further assist elderly and handicapped patrons by providing fare box railings and stanchions to deter accidents which could be caused by sudden bus movements.

g. An UMTA grant to the Utah Transit Authority, in Salt Lake City, will provide for new buses with an extra light at the stepwell and a grab rail at the fare box. Both features should assist elderly and handicapped riders.

6. *Transit Planning*

a. A grant for a Special Transit Service Needs Study was provided to the Metropolitan Transportation Commission in Berkeley, Calif. This will identify the scope and magnitude of unmet transit needs among those restricted in mobility because of low income, age, or physical disability, and will recommend specific means of increasing mobility for these groups. In Phase I of this two-phase project, travel needs will be estimated. Phase II includes pilot studies which will produce a recommended transit operations program serving these target groups.

b. A grant was made to the East-West Gateway Coordinating Council in St. Louis, Mo., to assist in a study administered through the Mayor's Office of Aging. The study was recently completed, and a draft report has been issued. The study objective was to develop a precise description of the transportation problems of the elderly and handicapped of St. Louis, and to formulate an operational solution of these problems.

c. Rockland County, N.Y., has completed a study which developed data on the transportation needs of the elderly, handicapped and other disadvantaged residents; made a determination of the transit improvements required to meet these needs; proprosed optional system designs incorporating these requirements; and developed a support and implementation program for the long-term maintenance of the proposed system.

d. A study is now underway in Westchester County, N.Y., that will identify the transportation needs of the elderly and handicapped and other disadvantaged residents; make a determination of the transit improvements required to meet these needs and proposed optional system designs incorporating these requirements; and develop a support and implementation program for the long-term maintenance of the proposed system.

B. RURAL TRANSPORTATION

1. *Recently Completed Research*

The Department has recently completed an evaluation of rural transportation demonstration projects and is using findings to publish a manual which identifies the characteristics of those projects which appear to be important to the successful development and operation of rural public transportation programs. Many of the projects that were evaluated played a major role in transporting the elderly population to and from services. During 1974, the Department expects to use the manual in the development of policy and programs related to transportation of the elderly in rural areas.

2. *Ongoing Research*

a. The Department's University Research Program has recently funded a rural public transportation feasibility study which should prove helpful to elderly persons without access to automobiles living in rural areas. The overall objective of the study is to determine what kinds of transportation systems are best suited for various local situations in rural America.

b. The Federal Highway Administration (FHWA) is supporting a study of ways to obtain increased use of existing vehicles (taxis, private automobiles,

buses) by the elderly, the poor, and the handicapped living in rural areas. December 1974 is the scheduled completion time for the study.

C. AVIATION

The Federal Aviation Administration (FAA) has a rulemaking action under review directed toward providing uniform criteria for transportation of mobility-restricted persons in civil air carriers. During 1973, the FAA held a series of public hearings after receiving more than 300 public comments on its advance notice of proposed rulemaking. FAA expects to finalize the rulemaking process by instituting a regulation relating to carriage of the handicapped during the first half of 1974. While the physically handicapped will be prime beneficiaries of this action, we anticipate that the mobility-restricted elderly will also derive benefits.

D. HIGHWAYS

FHWA is providing staff support to the Southeast Federal Regional Council's "Expanded Metro Mobility Project," which will coordinate transportation funds from several Federal agencies to increase the efficiency of an existing rural transportation system—improvements which will particularly redound to the benefit of the elderly and the handicapped.

E. RAILROADS

1. *Equipment and Facility Design Standards*

The Federal Railroad Administration (FRA) has continued to cooperate with the marketing and operating departments of Amtrak to assure that new equipment design, and new or renovated terminals, include features to facilitate movement of elderly and handicapped individuals. In an engineering design study of a contemplated new metroliner train station in New Carrollton, Md., the contractor has specific responsibility to include methods of easing the transportation problems of persons with limited mobility.

2. *Testing*

The special needs of the handicapped continue to receive attention at the FRA test center in Pueblo, Colo. A major activity of the center is the testing of the capabilities of conventional and advanced designed passenger equipment.

F. TRANSPORTATION SAFETY

The Department's National Highway Traffic Safety Administration is continuing to support efforts to develop a vision-testing device which will discriminate among drivers as to their visual condition as this relates to driving capability. This device should prove helpful to the elderly, inasmuch as some States require them to undergo rigid physical and driving examinations in order to renew their driver's licenses.

G. OTHER ACTIONS

1. Transportation needs of the elderly continued to be known directly to the Department through eight consumer public hearings or "listening sessions" held in five States by the Department's Office of Consumer Affairs during 1973. Through the end of calendar year 1973, consumers from seventeen States had participated in a total of fourteen hearings. In addition, the elderly's concerns about the quality of transportation services are being made known through those senior citizens who are serving on the Department's Citizens' Advisory Committee on Transportation Quality.

2. The Department continued to maintain a close working relationship with other Federal departments and agencies and to seek avenues for cooperative working relationships on behalf of the elderly. For example, this Department and the Administration on Aging of the Department of Health, Education, and Welfare are working together to determine how the resources of the two agencies can be combined to improve transportation which is necessary for the elderly to take advantage of services provided by a variety of Federal, State, and local agencies as well as non-governmental agencies and organizations. In addition, the Department participates in the Interdepartmental Task Force for Research in

Aging which functions under the direction of the Domestic Council Committee on Aging. A major objective of this body is the coordination of Federal research and related activities relevant to our elderly population.

ITEM 12. DEPARTMENT OF THE TREASURY

JANUARY 18, 1974.

Dear Mr. Chairman: On behalf of the Secretary of the Treasury and myself, I am furnishing you with a summary of Internal Revenue Service activities benefiting the elderly during 1973. Our efforts during 1974 will be largely along the same lines, and we hope and expect to improve our programs. We are making a major effort to inform elderly taxpayers, and others, of their tax rights and responsibilities, and to simplify our forms and instructions. I surely hope that Congress will act to simplify the tax law, particularly the retirement income credit.

If we can provide additional assistance to the Committee, please call upon us.

With kind regards,

Sincerely,

DONALD C. ALEXANDER,
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 1973 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

Elderly taxpayers will find a number of time-saving improvements on 1973 individual income tax returns. These major improvements include:

—elimination of income limitations for filing the 1040A short form;
—elimination of schedule B for reporting details of dividends and interest;
—elimination of the requirement to list contributions for which the taxpayer has cancelled checks or receipts;
—elimination of the requirement to list names and dates for claiming payments to doctors, dentists and hospitals; and
—reduction in the number of revenue sharing questions to a single item.

Taxpayers will also find two lines on their returns relating to the 1976 presidential election campaign fund checkoff: one line permitting them to check off for 1973, the other providing a second opportunity for those who failed to check off on their 1972 returns and now wish to do so.

Moreover, the instructions to the tax forms have been carefully reviewed and simplified. The Service has not only shortened the instructions but has rewritten much of the material in easier-to-understand language. Steps taken by the Service to improve the tax forms and instructions should enable many elderly taxpayers to complete their returns with less difficulty and in less time than last year. In addition, the Form 1040 tax package will continue to include an order blank which will make it possible for older citizens, and other taxpayers, to obtain needed forms and publications by mail.

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).

The number of aged taxpayers needing assistance in the arithmetic involved in computing their tax should be reduced due to: (1) improved tax forms and instructions, (2) the Service's willingness to compute tax on any Form 1040A return, and (3) the Service's continuing offer to compute retirement income credit, and the tax, on Form 1040 returns with standard deduction and wage, dividend, interest, pension, or annuity income up to $20,000.

Taxpayer Assistance Training

During 1973, 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 2 days of training to over 5,000 senior citizens, who, 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. Nearly 215,000 elderly taxpayers received tax assistance through the VITA program in 1973, representing four times the number assisted in 1972.

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 1973, elderly tax assistance centers were established in major cities in every State.

Another way in which instruction is made available to senior citizens is through adult education programs cosponsored 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 50,000 persons.

In an effort to help Federal employees adjust to retirement years, additional copies of the instructor's guide for the preretirement 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 some 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. The toll-free telephone system has now been implemented nationwide and will greatly expand the Service's ability to respond to specific taxpayer inquiries. 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. Pre-filing review of returns, initiated last year on a test basis, will also be carried out in all offices at the taxpayer's request. The Pre-filing review is designed to pick up errors or omissions on returns before they are filed and thereby avoid extended processing delays that would otherwise occur. Test of mini-computer returns preparation will be continued through the 1974 filing period. 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 5, 1974.

DEAR SENATOR CHURCH: This letter is in response to your request of December 21, 1973, asking for a statement regarding Federal Trade Commission policies and actions affecting older Americans.

As you are no doubt aware, none of the laws enforced by the Federal Trade Commission are directly and solely applicable to the aged. However, older Americans are particularly vulnerable to fraud and deception. Therefore, the Commission's efforts to prevent fraud and deception in the marketplace and to educate the consumer are certainly of value to the aged.

I hope this information will be of some assistance. Please contact me if you have need of further information.

Sincerely,

LEWIS A. ENGMAN,
Chairman.

[Enclosure]

STATEMENT ON ACTIONS AND POLICIES AFFECTING THE AGED, FEBRUARY 1974

The Federal Trade Commission seeks to protect and promote the interests of consumers in a free and competitive marketplace, through its authority to proceed against all unfair and deceptive acts or practices and unfair methods of competition in commerce. The Commission is concerned with those marketing practices which diminish the consumer's ability to protect his own interests, and with those competitive abuses which lessen competitive pressures to keep prices low and product quality high. The Commission also seeks to foster self-protection and encourage more competition by increasing the flow of relevant information about consumer products.

Most of the Commission's activities in the past year were designed to protect and promote consumer interests generally, rather than the interests of any particular segment of the population. To the extent, however, that the Commission's activities may have helped to prevent the fraudulent inducement of consumer expenditures, or may have helped to preserve competitive pressures to keep prices down, such activities would be of particular benefit to those groups of consumers with fixed and limited incomes. One such group is the aged population.

A major and continuing concern is the regulation of national advertising. For the last several years, the Commission has devoted substantial resources to this area. The Advertising Substantiation Program is a primary effort in the regulation of national advertising, as is the agency's promotion of informative advertising.

Additional areas of continuing concern include:

—Door-to-door sales.
—Franchising.
—The hearing aid industry.
—Drugs and cosmetics.

Other areas in which the Commission has initiated studies or cases include:

—The funeral industry.
—Health spas.
—The oil industry.
—Unfair credit and credit reporting practices.
—False advertising in nutritional value and price of food.

The Federal Trade Commission also is concerned with education of the consumer. Through the Division of Consumer Education, the regional office network, and a variety of pamphlets, bulletins and other publications, the Commission seeks to make the consumer aware of potential fraud and deception. The Division of Consumer Education recently prepared an education packet on vocational

schools for use by consumer groups. Each regional office has established extensive contacts with consumer groups as well as State and local government units to insure maximum exchange of information and coordinated attacks to consumer problems. Examples of brochures and pamphlets are enclosed.

The Commission will continue to give priority to projects and actions which provide benefit to the widest possible numbers of the public, including our older citizens.

ITEM 14. FOOD AND DRUG ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE

MARCH 11, 1974.

DEAR MR. CHAIRMAN: On behalf of Commissioner Schmidt, I am submitting the enclosed statement from the Food and Drug Administration to be included in the Committee's annual report for 1973.

We appreciate the opportunity to report on the Food and Drug Administration's activities to protect the Nation's older consumers.

Sincerely yours,

ROBERT C. WETHERELL,
Acting Director, Office of Legislative Services.

[Enclosure]

FDA ACTIONS TO PROTECT THE OLDER CONSUMER

The Food and Drug Administration's most important action to protect older consumers in 1973 was the issuance of nutrition labeling regulations for foods generally and dietary supplements (vitamins and minerals) in particular.

The regulations are the culmination of more than 10 years of study by the FDA with the help of the scientific nutrition community. They also reflect many recommendations of the 1969 White House Conference on Nutrition and Health.

Older Americans especially, need food labels that will aid them in identifying and selecting a nutritious diet.

Many factors underlie the need for such regulations—changed eating habits, increased popularity of various foods and declining use of others, studies showing dietary deficiencies in specific population groups, and widespread misinformation on matters of diet and health.

The regulations are tied in with nutritional standards for foods, including such products as frozen dinners which are much relied on by persons who live alone or are not able to do much cooking.

A new yardstick of nutritional values—the U.S. Recommended Daily Allowances (RDA) for vitamins, minerals, and protein—was officially adopted, replacing the former FDA "Minimum Daily Requirements" (MDR). Twenty nutrients are covered by RDA's, in contrast to only 10 with MDR's.

The new regulations deal with three categories of products:

(1) *Foods containing less than 50 percent of the U.S. RDA in a serving.*—If these have added vitamins and minerals, or if any nutritional properties or benefits are claimed for them, they will be required to have nutritional labeling in 1975. But any food may have nutrition labeling if it complies with the regulations, and many products already have it.

The required labeling format as a minimum calls for listing the number of servings per container, serving size, the amount of calories, carbohydrates, fat and protein per serving, and the percentages of the U.S. RDA per serving for protein and seven key vitamins and minerals. Other essential nutrients may be listed if they contribute at least 2 percent of the respective U.S. RDA. A companion regulation specifies the location and conspicuousness of this information on the label.

For the first time, manufacturers will also be permitted to label foods with the cholesterol content and a breakdown as to saturated and unsaturated fats. This information will be especially useful to persons who, on the advice of a physician, are on a fat modified diet. The format also provides for labeling of sodium content, important in certain cardiovascular and kidney conditions.

(2) *Foods fortified to contain 50 to 150 percent of the U.S. RDA.*—There are "special dietary foods," and include the "food supplements," vitamins, minerals,

and other nutritional products commonly sold in drug and health food stores. Standards and labeling required for these food supplements are designed to reduce confusion, deception, waste and false or misleading health claims which the courts have held illegal on the basis of scientific evidence.

Specifically prohibited are:

Claims that products intended to supplement diets are sufficient in themselves to prevent, treat or cure disease.

Any implication that a diet of ordinary foods cannot supply adequate nutrients.

Claims that inadequate or insufficient diet is due to the soil in which a food is grown.

Claims that transportation, storage or cooking of foods may result in inadequate or deficient diet.

Any nutritional claims for non-nutritive ingredients such as rutin, other bioflavonoids, para-aminobenzoic acid inositol, and similar ingredients. (Their combination with essential nutrients is prohibited.)

(3) *Products fortified to contain over 150 percent of the U.S. RDA.*—Generally sold in capsule or tablet form, these are required to be labeled as over-the-counter (non-prescription) drugs. Two products, those containing Vitamin A in doses above 10,000 International Units, and Vitamin D in doses above 400 I.U., are unsafe for self-medication because of injurious side effects, and require a prescription.

A mass publicity campaign against the FDA regulations was launched by the "National Health Federation" which claims to represent the health foods industry. (See attachment A, p. 271.) It was charged that the public would be forced to get prescriptions to buy ordinary vitamins, that many products would be taken off the market, and that health food dealers would be forced out of business. Several law suits were filed to block the rules from becoming effective and legislation was introduced for the same purpose. The Food and Drug Administration emphatically rebutted all such allegations as false.

Only very high potencies of certain vitamins require prescription because of well-established hazards from overdosage. Not a single nutrient previously available has been banned from sale. This being the case the regulations could not possibly put health food dealers out of business.

The controversy over the vitamin-mineral regulations made headlines across the country. The misinformed opponents of the rules wrote thousands of protests to members of Congress—last year the House, this year the Senate. The scientific community supported FDA, as did the prestigious American Association of Retired Persons, and the National Retired Teachers Association, which informed their 6.3 million members in detail concerning the issues involved. (See attachment B, p. 274.) All sides of the matter were aired in hearings October 29–30, 1973, before the Subcommittee on Public Health of the House Committee on Interstate and Foreign Commerce.

The dietary supplement regulations are only part of a larger package which is not in controversy. But they involve the very important issue whether consumers are to be protected against exaggerated claims and other deceptive practices in the marketing of vitamins and other food supplements. The courts have continued to uphold the FDA in precedent-making cases. There were three such cases in 1973:

A Court of Appeals upheld a District Court decision refusing to enjoin enforcement of regulations requiring that preparations of Vitamin A and D in excess of certain amounts per dosage unit be restricted to prescription sale and labeled accordingly. The District Court concluded that the administrative decisions, which were based on evidence of the toxicity of large amounts of either vitamin, were reasonable and rational to protect the public interest. *National Nutritional Foods Association* v. *Weinberger*, CCH F.D. Cosm. L. Rep. ¶ 41,041 (2nd Cir., 1973).

A Court of Appeals upheld the decision of a District Court that Nuclomin, a dietary supplement of vitamins and minerals, was in violation of the food misbranding provisions of the Federal Food, Drug, and Cosmetic Act since its label made false and misleading representations concerning the nutritional value of the product. The Court ruled that ingredients which are present in small amounts so as not to have any value to supplement the diet must not be listed on the label of a "dietary supplement." *United States* v. *An Article of Food . . . . Nuclomin*, 482 F.2d 581 (8th Cir., 1973).

A District Court decided that Nutri-Way, a vitamin and mineral supplement, was in violation of several food misbranding provisions of the Act. The Court found that the mere listing of ingredients of no nutritional value and insignificant amounts of ingredients of recognized nutritive value in the labeling of a vitamin mineral supplement falsely and misleadingly represents to the public that such ingredients (1) make a significant nutritional contribution to the product, (2) in fact have nutritive value, and (3) significantly enhance the product's nutritional value. *United States* v. *An Article of Food. Nutri-Way*, CCH F.D. Cosm. L. Re. ¶41,026 (N.D. Tex., 1973).

Study of Health Practices and Opinions

The national Study of Health Practices and Opinions, suggested by the Committee on Aging after hearings in the mid-1960's, was completed in 1970 and its final report was published October 9, 1972. It continues to be of wide public interest.

This unique psychological research project was designed to determine public attitudes on health matters and factors responsible for susceptibility to health frauds and quackery, particularly among the elderly—a subject of the Committee's hearings.

The 456-page report was published by the National Technical Information Service, U.S. Department of Commerce. (Accession No. PB 210-978, "A Study of Health Practices and Opinions. Price $6.00.) Sales of the report to date (Feb. 7, 1974) total 1,532.

Major areas reported on are as follows:

(1) Susceptibility to misinformation regarding the effectiveness of diet, special dietary foods, vitamins and minerals in self-medication.

(2) Opinions and beliefs related to the use of so-called "health foods," "organic foods," and foods in general.

(3) Beliefs and practices in the area of dieting for weight control without medical supervision.

(4) The misconception that daily bowel movements are a necessity for good health, leading to excessive use and dependence upon laxatives, special foods, or enemas, without medical supervision.

(5) Self-diagnosis of such conditions as arthritis/rheumatism, asthma, allergies, hemmorrhoids, heart trouble, high blood pressure or diabetes.

(6) Self-medication and the tendency to prolong self-treatment for sore throat, coughs, sinus trouble, head colds, hay fever, skin problems, insomnia, and upset or acid stomach.

(7) Self-medication for serious ailments (heart trouble, high blood pressure, diabetes, asthma, allergies, hemorrhoids).

(8) Self-treatment for arthritis/rheumatism.

(9) Reliance on and belief in unproven remedies for cancer.

(10) Opinions concerning health practitioners and their qualifications to treat various conditions.

(11) Attitudes toward hearing problems and the purchase of hearing aids.

(12) Use of advertised products to enable one to quit smoking.

The report is indexed by NTIS under the topics of:

Susceptibility to health fallacies and misrepresentations; quackery; empiricism; self-diagnosis; self-medication; health education; vitamins; health foods; weight reduction; laxatives; arthritis treatments; cancer treatments; health practitioners; psychological orientations regarding personal health; hypochondria; psychosomatic effects; demographic factors affecting health behavior; aging as a factor in health beliefs and practices.

The attached press release (see attachment C, p. 275) describes the Study, which was widely covered by the press. The findings continue to stimulate educational publicity, for example, an article on the risks of self-medication in the March 1974 issue by Woman's Day magazine ("Do-it-yourself Medicine: How Much is Safe", by Walter E. O'Donnell, M.D.)

The principal findings on health beliefs and behavior of older Americans were summarized in the report as follows:

—Older people, as a group, seem no more inclined to *worry* about their health than youger people.

—Older people are more critical of doctors and the medical profession, and seem somewhat more susceptible to certain practices associated with unethical "doctors" (the latter difference is not striking). However, they are

less likely than young people to rely on their own judgment when it conflicts with that of a physician.
—Susceptibility to medicine advertising and labeling claims is unrelated to age, and older people seem more skeptical than young ones about the efficacy of drug store remedies. Prolonged self-medication of common ailments is more characteristic of young people than old people.
—Older people seem to be more impatient for results from medication.
—Older people are less likely than younger people to engage in questionable use of nutrition supplements.
—Older people were less likely to engage in questionable weight control practices.
—Among those who have such serious ailments as heart disease and high blood pressure, older people seem no more likely than younger ones to engage in self-medication. However, many more older people have these conditions, of course.
—More older people were relying on self-diagnosis of various ailments, but more older people also had had the same ailments diagnosed by a physician, so any tendency of older people toward self-diagnosis is due more to their greater frequency of problems than to any special reliance upon self-diagnosis.
—Several questionable practices relating to arthritis/rheumatism are especially characteristic of older people. They more often suffer these symptoms, of course, but even among sufferers older people were more likely to pursue questionable practices than younger people.
—Older people more often use health practitioners who are not "regular physicians".
—Older people are much more likely to have hearing problems, but among those with problems they are less likely than younger people to follow questionable practices.
—Older people are more prone to over-reliance upon bowel movement aids.
—Older people reported more doubts about the healthfulness of the nation's food supply, and a somewhat greater incidence of health food usage.

[Attachment A]

MEMORANDUM

MAY 15, 1973.

To: Acting Commissioner of Food and Drugs
From: Deputy Assistant Commissioner for Public Affairs, Director, Office of Legislative Services
Subject: Report on the National Health Federation—Information Memorandum

This memorandum updates a previous memorandum issued October 21, 1963, and is intended to provide you with background on the activities of the National Health Federation. Currently, this organization is promoting a mass write-to-Congress campaign against the recently issued special dietary food regulations, and urging support for H.R. 643, a bill which would virtually destroy all FDA control over the health claims made for special dietary foods. The Agency is receiving numerous Congressional and public inquiries as a result of this campaign.

The National Health Federation was founded in 1955 by Fred J. Hart, shortly after he consented to a Federal court injunction prohibiting him from making further shipments of 13 electrical devices which had been widely distributed for the diagnosis and treatment of disease. Mr. Hart had for many years been president of the Electronic Medical Foundation, previously known as the College of Electronic Medicine. The "College" was established by the late Dr. Albert Abrams, inventor of a "blood spot" system of diagnosis known as "Radionics."

Following the injunction, the Food and Drug Administration investigated reports that Hart was continuing to distribute the devices. He was prosecuted for criminal contempt of the injunction and on July 27, 1962, he was fined $500 by the U.S. District Court at San Francisco. At that time the court was informed that the Electronic Medical Foundation had been discontinued on June 16, 1962 leaving Mr. Hart free to devote his efforts to the National Health Federation.

The major stated purpose of the Federation is to promote "freedom of choice" in health matters. The record shows that what this frequently means is freedom to promote medical remedies and devices which violate the law. From its inception, the Federation has been a front for promoters of unproved remedies and

eccentric theories. It has consistently supported discredited medical treatments such as the outlawed Hoxsey cure for cancer and other equally worthless treatments. Currently they are promoting Laetrile.

Results of Court Actions

Court records show that a number of the founders, officers, directors and active members of the National Health Federation have been involved in court actions under the Federal Food, Drug, and Cosmetic Act.

Among those prosecuted, fined and/or imprisoned have been the following:

Fred J. Hart, founder and now Chairman of the Board. Mr. Hart was enjoined with the Electronic Medical Foundation on March 15, 1954, from distributing 13 electrical devices charged as misbranded with false claims for the diagnosis and treatment of hundreds of diseases and conditions. In 1961 he was prosecuted for violating the injunction, entered a plea of "no contest" and was fined $500 on July 27, 1962, by the U.S. District Court at San Francisco.

V. Earl Irons, Chairman of the Board of Governors (1963). Mr. Irons was then a food supplement distributor who served a one-year prison sentence in 1957 for misbranding Vit-Ra-Tox, a vitamin mixture sold by house-to-house agents. His conviction by the Federal District Court at Boston was upheld by the U.S. Court of Appeals on April 24, 1957.

Royal Lee, deceased Director, member of the Board of Governors and one of the founders of the Federation, was a non-practicing dentist at Milwaukee who was twice convicted for violating the Federal food and drug law. On April 23, 1962, he was given a one-year suspended prison sentence and put on probation for three years by the Federal District Court at Milwaukee. His firm, Vitamin Products Company, was fined $7,000. A court order prohibited them from continuing to ship 115 special dietary products misbranded by false claims for the treatment of more than 500 diseases and conditions.

Roy F. Paxton, Director (term ending in 1963) was twice convicted as the promoter of "Millrue," a worthless cancer remedy. Mr. Paxton was convicted the second time in February 1962 by the Federal District Court at Springfield, Illinois. He was fined $2,500 and served a three-year prison sentence. The corporation, Millpax, Inc., was fined $1,000.

Andrew G. Rosenberger, listed as "Nutrition Chairman" and a featured speaker at NHF national conventions. Mr. Rosenberger representing the firm "Nature Food Centers," at Cambridge, Massachusetts, was convicted of misbranding dietary food products. On June 19, 1962, Andrew Rosenberger and his brother, Henry, were each fined $5,000 and the corporation was fined $10,000 by the Federal District Court at Boston. Each of the Rosenbergers received a six-month suspended prison sentence and was put on probation for two years. The sentences were upheld by the Court of Appeals.

The Washington representative of the Federation continues to be Clinton R. Miller, Vice President. Before coming to Washington, Mr. Miller was the proprietor of the Clinton Wheat Shop at Bountiful, Utah. One of his products, Dried Swiss Whey, was seized on charges that it was misbranded as a treatment for intestinal disorders.

The aims and purposes of the National Health Federation are shown by its monthly publication, *National Health Federation Bulletin*, a pocket-size magazine published at San Francisco with Fred J. Hart listed as "Managing Editor."

Recent Developments

On April 9, 1971, Kurt W. Donsbach, currently Vice President of NHF, pleaded guilty to practicing medicine without a license on charges brought by the State of California. According to the State records, the case culminated a five-month investigation by the Fraud Section of the State Bureau of Food and Drug Inspections.

Undercover agents of the California State Bureau of Food and Drug Inspections made repeated visits to Donbach's "Nature's Way Health Food Store" in Garden Grove, California. They reported business "very good," usually with about 15 persons waiting to see "the doctor." Donsbach represented himself as a chiropractor, a naturopath, and a "Bachelor of Therapeutic Science." Investigation disclosed he is not licensed as a chiropractor in California, and the State does not recognize the other credentials. His driver's license identified him as an M.D.

The case resumé states that the California agents found that Donsbach was receiving "patients" in his "consulting room" and prescribing organic vitamins, minerals, etc. for disorders ranging from spastic colons to menopause and from serious heart ailments to breast cancer.

A woman agent was told by Donsbach on several occasions that her "breast cancer" could be controlled if she followed his advice and adhered to a strict diet with vitamins, minerals, and a herbal tea called "chapparral."

Another woman agent was told that her "emphysema" and "heart condition" would be helped 100 percent by following a regimen of vitamins, minerals, and herbs.

A man agent was instructed to take cabbage tablets daily to cure "stomach ulcer."

The cost of Donsbach's treatment to the woman agent with "breast cancer" would have been approximately $60 per month. With this as a yardstick for ten patients daily, and a five-day week, the California authorities estimated a gross income to Donsbach of around $2 million a year.

Donsbach was fined $750 plus $2,000 costs of investigation, and placed on probation for two years. Additionally, he consented to stop all "nutritional consultation" in the State of California.

Aside from his "health food" store, Kurt W. Donsbach is president of Westpro Labs, Inc., of Garden Grove, California. The firm's stationery indicates it deals in proteins, vitamins, stock formula, private labeling, custom formulation, contract development, market research, and unusual cosmetics.

The NHF continues to advocate and defend ill-founded and unsupported theories and practices, even for the treatment of serious disease conditions such as those described above, under the guise of the "right to freedom of choice" in health matters. The NHF contends that only those products and procedures which are intrinsically injurious should be legally restricted. This philosophy, of course, exposes innocent members of the public to worthless products, false hopes, and a return to the long discarded philosophy—"let the buyer beware!"

Such a philosophy fails to recognize the danger of reliance on unproven or ineffective agents in the treatment of serious disease which can be just as dangerous to the patient as the use of intrinsically injurious substances. One example of this NHF position is the continued advocacy in their association journal of the "right" of persons to obtain cancer remedies which are illegal in the United States because their merits, even for research purposes, have not been established.

NHF maintains that there is a right to sell food and other articles for their presumed health benefits, whether or not there is any scientific evidence to support the claims to promote them. A good example will be found in the November 1972 *National Health Federation Bulletin.* This issue contains an article entitled "How to Survive in a Poisoned World," by Paavo O. Airola, an Arizona naturopath. The article exaggerates the effects of air and water pollution and then prescribes approximately a dozen "health foods" and vitamins and minerals as effective antidotes. Scientifically, the material is nonsense. This type of literature also provides unethical or misguided dealers in such products with sales promotion material which exploits widespread fears and misconceptions.

Currently, NHF is carrying on a lobbying campaign in Congress against FDA's regulations which update obsolete (1941) rules on the labeling of special dietary foods. Under the laws as passed by Congress in 1938, the label for a food for special dietary uses must include "such information concerning its vitamins, minerals, and other dietary properties" as the regulation prescribes as "necessary in order to fully inform purchasers as to its value for such uses." The law also authorizes FDA to establish standards of quality and identity for food, including food supplements. The NHF's expressed philosophy is wholly contrary to the intent of Congress in enacting these laws. Further, their exaggerated views concerning the value of most vitamins and minerals and many other substances are not supported by recognized nutrition and medical authorities both inside and outside Government.

Directly related to the National Health Federation campaign against the FDA's dietary food regulations is a massive campaign for legislation which would exempt "health food," vitamins, minerals, etc., from being proven safe and effective by their sponsors when they are offered for the treatment of diseases. Present law offers full consumer protection by requiring that articles intended to treat disease conditions must be proven to be safe and effective *before* they can be placed on the market. Legislation being advocated by NHF would substantially

weaken this protection which has been part of our law since 1938. The NHF bill (H.R. 643) would bring about this rollback in consumer protection by permitting the marketing of articles used in treating disease conditions without any assurance that they are safe and effective. The burden would be shifted to the Government to detect and remove dangerous products *after* they have been marketed (i.e., locking the barn door after the horse is stolen). In the meantime, of course, the public is exposed to such dangerous untested and ineffective products. Thus, a loophole would be opened for a return of the infamous "patent medicine" style of promotion, with "food supplements" taking the role of the "snake oil" remedies of bygone times; good for everything.

The NHF sponsored legislation would also reverse requirements of present law regarding proof of safety of food additives. In addition, present law deems a food to be adulterated if it contains a substance which "may be" injurious to health; yet the NHF bill would permit protective action only when a product is intrinsically injurious to health. Here again, this legislation would inappropriately shift the burden to the Government rather than the manufacturer who should bear this responsibility when he undertakes to market a product. We believe most consumers would not want to lose this protection against potential hazards.

According to the U.S. Postal Service, paid subscriptions to the NHF Bulletin (sworn statement filed August 18, 1972) totaled 18,173. Membership, however, is estimated to be about 10,000.

We, of course, are concerned about the effects of this campaign on the uninformed consumer. We will continue to monitor the inquiries received. The Department's formal bill report on this legislation has been issued and, at least, members of Congress now have more detailed information on the impact of this bill.

JOHN T. WALDEN.
GERALD F. MEYER.

[Attachment B]

THE STORY BEHIND FDA VITAMIN, MINERAL PROPOSAL

Controversial new proposals by the Food and Drug Administration (FDA) for regulating vitamin and mineral use have been strongly endorsed by NRTA-AARP after a thorough investigation by representatives of the NRTA-AARP Pharmacy Service.

According to John R. McHugh, national manager of the Pharmacy Service, "the basic purpose of the FDA action is to protect consumers from being misled into buying dietary supplements which are so weak that they are useless or so potent that they go beyond any reasonable level of diet supplementation."

Statements by various groups opposing the regulations that "the government is trying to take away your vitamins" are just not true, McHugh said.

"The FDA has made it clear to us that they are not removing any vitamin or mineral from the shelves or restricting any to solely prescription use at this time," McHugh said. "Further, they are unlikely to place prescription-only requirements on any vitamins and minerals in the future, and no manufacturer who is willing to properly label his products will be adversely affected."

The new proposed labeling regulations, based upon new definitions, were released in January after a 10-year investigation by the agency of consumer needs and uses of vitamins and minerals, including two years of formal hearings during which representatives of medicine, science, industry and consumers expressed their views. The FDA is required, under the terms of the Food, Drug and Cosmetic Act of 1938 to insure safety with efficacy, as well as complete consumer information, relative to these products.

Years ago, FDA spokesmen point out, it was generally believed that massive doses of vitamins were harmless—one had "nothing to lose and everything to gain." Modern medical research has now proven otherwise. Excessive amounts of certain vitamins—particularly vitamins A and D—are not thrown off by the body but are instead stored because they are fat soluble. It is known now that prolonged, massive doses of Vitamin A can cause pressures within the skull that may be mistakenly diagnosed as the symptoms of a brain tumor. Useless, dangerous and costly surgery may result. It is also known today that too much Vitamin D can produce calcification in soft tissues and bone deformity in both adults and children.

The new FDA proposals are based upon modern research into basic human nutritional needs and were the result of an exhaustive study by the National

Academy of Science, using the best available scientific evidence on what daily amounts of vitamins and minerals are actually needed to maintain positive good health. The proposals replace the present Minimum Daily Requirements (MDRs) with a new definition—Recommended Daily Allowances (RDAs). These RDAs are generally higher and more liberal than the MDRs, which were originally developed during World War II in case of food shortages and are actually "rock bottom" minimum amounts aimed at preventing malnutrition.

Any product which contains less than 50 per cent of the vitamins and minerals necessary to maintain good health (RDA) is called a "food" in the new definitions. Products fortified with 50 to 150 percent of RDA are called "dietary supplements." Products with over 150 percent of the RDA are labeled as "drugs". (Two exceptions are vitamins A and D, which will be labeled as drugs when they exceed 100 percent RDA, rather than 150 percent).

This last definition does not mean, however, any automatic restriction on the sale of these substances, a fact which is apparently being widely misrepresented and generally misunderstood.

In the case of Vitamin A and D, for example, the FDA is recommending that doses over the 100 percent RDA level be taken under the guidance of a doctor. Nevertheless, those who wish for some reason to continue taking very large doses of these vitamins can still purchase as many 100 percent RDA tablets as they wish and take as many as they desire.

In proposing these new regulations, the FDA emphasizes that its purpose is not to "take away" vitamins or minerals. Rather, its purpose is to achieve clear, understandable labeling of these products which reflects true nutritional and medical facts.

In an attempt to counter myths and misunderstanding surrounding the new regulations, the FDA recently issued a definitive statement of its intentions:

"FDA is not saying that there is no loss of nutrients from cooking, storage, or transportation of conventional foods.

"The agency is not saying that soil composition does not cause variation in the nutritional content of food.

"The agency is not seeking to limit personal choice between the national and chemical form of supplementary nutrients.

"The agency is saying that in terms of overall diet, today's conventional foods can provide adequate amounts of all nutrients necessary to good health and that claims or implications to the contrary are misleading.

"The FDA will continue to regulate on the basis that vitamins and minerals are essential foods when taken according to bodily need. When taken far in excess of this need, they are *drugs* and should be treated by the consumer and the FDA accordingly."

Commenting on the AARP-NRTA support of the FDA action, the first such endorsement by any major national organization, McHugh said, "While the Pharmacy Service sells a great many vitamins and minerals, we are not in business to make a profit; rather, we seek to provide a useful and necessary health service for our member-consumers. Accordingly, we support efforts by the FDA and others to clarify the nature of products in the market place and better equip the consumer to know what he or she is buying and to get the most for his or her dollar."

[Attachment C]

HEW NEWS

STUDY OF HEALTH PRACTICES AND OPINIONS

FOR RELEASE: MONDAY—OCTOBER 9, 1972

People in the United States are among the best educated in the world, yet millions make decisions on their personal health problems believing that "anything is worth a try."

This trial and error approach to solving personal health problems is the major underlying cause of questionable health practices in the U.S. population, according to the results of a national study released by the Department of Health, Education, and Welfare.

The study found that millions of consumers base important health decisions on the idea that since there are individual differences in people there is a chance that almost any treatment may be beneficial. Faith in this trial and error approach is reinforced by psychosomatic effects and unaided recovery.

Some highlights of the study:

- Older people are generally less likely to make irrational decisions on health problems and more skeptical about efficacy claims for drug store remedies than young persons.
- Forty-two percent of the people interviewed, representing 50 million adults, would not be convinced by almost unanimous expert opinion that a hypothetical "cancer cure" was worthless. Only 45% thought such a medicine should be banned by law.
- Three-fourths of the public believe that extra vitamins provide more pep and energy, the most common of the misconceptions investigated in the survey.
- Although their condition had never been diagnosed by a physician, 12% of those interviewed, representing about 16 million adults, reported they had arthritis or rheumatism, asthma, allergies, hemorrhoids, heart trouble, high blood pressure, or diabetes.
- Twelve percent of the sample also indicated they would self-medicate—without seeing a doctor—for longer than two weeks for ailments such as sore throats, coughs, sleeplessness or upset stomach.
- Twenty-six percent, representing about 35 million adults, had used nutritional supplements expecting specific observable benefits without a physician's advice.
- About two percent, representing 2½ million adults, indicated they did something every day or nearly every day to help with bowel movement, and that they were not following a physician's advice.

The research on health practices and opinions was initiated at the suggestion of the Senate Committee on Aging after hearings on how elderly consumers were being victimized by frauds and misrepresentations. The purpose of the survey was to investigate false and questionable health beliefs and practices and the public's susceptibility to them. The results are expected to be useful in strengthening educational and regulatory efforts to protect consumers.

Commenting on the results of the study, Dr. Merlin K. DuVal, HEW Assistant Secretary for Health and Scientific Affairs, said: "The attitudes, beliefs and practices of consumers in regard to health problems are critically important. They involve, for example, such questions as the limitations of self-diagnosis how long self-medication is continued, and when to seek professional care. Too little is known about present-day human behavior in health matters. The report provides us with background for decisions in areas such as health and nutrition education and drug labeling."

The 426-page report, "A Study of Health Practices and Opinions," was made by National Analysts, Inc. of Philadelphia, Pa. The study, which includes 110 statistical tabulations, is based on data from interviews with 2,839 adults in a national area probability sample during the summer of 1969. Major areas of health beliefs and practices singled out for specific investigation include:

—Susceptibility to misinformation regarding the effectiveness of diet, special dietary foods, vitamins and minerals in self-medication.
—Opinions and beliefs related to the use of so-called "health foods" and foods in general.
—Beliefs and practices in the area of dieting for weight control without medical supervision.
—The misconception that daily bowel movements are a necessity for good health, leading to excessive use and dependence upon laxatives without medical supervision.
—The tendency of persons to prolong self-treatment, without consulting a physician, for sore throat, coughs, acid stomach, headache and skin rash.
—Self treatment for arthritis and/or rheumatism.
—Belief in unproven remedies for cancer.
—Belief that non-prescription treatments will cure, rather than merely provide relief for asthma, allergies, diabetes and hemorrhoids.
—Opinions concerning health practitioners.

The $157,000 contract for the study was funded jointly by seven Government agencies: National Institute of Mental Health, Food and Drug Administration, Administration on Aging, National Institute of Child Health and Human De-

velopment, Vocational Rehabilitation Administration, Agricultural Research Service of the U.S. Department of Agriculture, and the Veterans Administration. FDA was the contracting Agency.

Roy G. Roberts, of National Analysts, Inc., was the study director. Wallace F. Janssen was the Project Officer for the FDA.

Complete copies may be purchased at $6.00 each from the National Technical Information Service, Springfield, Virginia 22151. Orders should specify "Accession No. PB 210-978, A Study of Health Practices and Opinions." Checks may be made payable to "NTIS."

ITEM 15. NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
Bethesda, Md., February 22, 1974.

DEAR MR. CHAIRMAN: Thank you very much for your letter of February 15 concerning the annual report of the Special Committee on Aging. I deeply regret that your earlier letter has been misplaced and that we have neglected to send you the National Institute of Child Health and Human Development contribution to your report.

The Institute's 1973 summary of activities in aging research is enclosed. I hope that our delay in transmitting the report has not seriously inconvenienced the Committee.

Sincerely yours,

GILBERT L. WOODSIDE, Ph. D.,
Acting Director,
***National Institute** of Child Health*
and Human Development.

[Enclosure]

RESEARCH IN AGING

THE EXTRAMURAL AGING RESEARCH PROGRAM

The study of the biological, psychological, and sociological aspects of aging covers a wide territory. Since it is impossible to investigate this territory in a comprehensive fashion, certain areas of special need and promise have been emphasized including biomedical aging, mental aging, and societal aging.

BIOMEDICAL AGING

The human organism is genetically programmed to develop from a fertilized egg to an adult. During development and after maturation various deleterious changes occur in the human body. Because the body does not possess the abilities to repair all these changes, some accumulate and result in the progressive deterioration called aging. At present, medical intervention can compensate for a small part of aging damage. One of the major aims of biomedical research is to make more extensive compensation possible. For example, intervention is already possible in the treatment of the menopause, the condition that results from ovarian aging. Probably in the future, physicians will be able to intervene more vigorously than now in the immunological deficiencies of the elderly. An understanding of the basic processes of cellular aging may open a number of therapeutic possibilities.

1. The Menopause

The female reproductive system undergoes enormous changes during the course of its development and decay. After a period of relative inactivity during childhood, ovarian activity increases dramatically at puberty. The body produces eggs and ovarian hormones in a strictly patterned reproductive cycle which, unless interrupted by pregnancy or modified by hormonal contraceptives, repeats itself with little variation until about the age of 50. At that time, and over a period of several years, ovarian activity falters and then almost completely ceases.

The hormones secreted by the ovaries through the reproductive years exert a profound influence on the maturation and maintenance of the breasts and sexual

organs. The great reduction in the ovarian excretion of estrogen during the menopause and in postmenopausal years causes atrophy of tissues previously stimulated by estrogen. In addition, hot flashes and episodic sweats may occur. The severity of these symptoms varies greatly among women and is probably related to the degree of estrogen deprivation. This, in turn, depends on how much function the ovary retains and how much estrogen is produced by tissues and organs other than the ovaries. It has been thought that other types of deterioration, such as osteoporosis and atherosclerosis, become worse with estrogen deprivation. The evidence for this, however, is not strong.

It has been known for several decades that the flashes, sweats, and genital atrophy associated with the menopause can be eliminated by the administration of estrogenic hormones. However, a great deal remains to be learned about who needs this treatment, what the best preparations are, what the dose schedule should be, and what the undesirable results of such therapy may be. Complications, particularly clotting in blood vessels and stroke, have already been caused by similar hormones used in contraceptive agents. There is some evidence that these complications are more frequent in older women of reproductive age.

The activation of the ovary at puberty is initiated by pituitary hormones produced under the control of the central nervous system. The cessation of ovarian activity at the menopause, on the other hand, is due to ovarian failure.

The mechanism of this is unknown, but it does provide an example of aging in a discrete organ proceeding more rapidly than the average rate of the rest of the body.

NICHD supports research on the other mechanisms that exist in the normal postmenopausal woman to compensate for the hormones no longer produced by the ovaries. The Institute funds, by contract, a retrospective study of the effect of estrogen therapy on the incidence of stroke in postmenopausal women.

2. Immunological Changes

The immunological changes that occur with age represent an important area for study because they are large and cause serious problems in the functioning of the elderly. When sufficient knowledge about immunological function and its changes with age have accumulated these may prove to be amenable to therapy. The progressive changes in immunologic function are especially interesting in that the immune system reaches peak development and begins its progressive decline with age before many other systems have reached maturity. Immune competence at birth is low, reaches a maximum value in the teens, and thereafter declines until in old age it may be as low as 5 percent of its previous highest value.

The importance of the immune system as a defense against infectious diseases has long been known. The elderly are particularly susceptible to infectious diseases. Much evidence has accumulated indicating that the ability to tolerate a number of infections is greater in childhood than in the adult years. In addition, it is also recognized that immunologic competence may play an important role in preventing development of cancer and of autoimmune diseases. The development of means of augmenting immune competence in the later years of life would represent an advance in improving the health of older people. Research toward this end is supported by NICHD.

3. Cellular Aging

Although complex systems may be modified to control some aging manifestations, more vigorous intervention might be possible if the cellular and subcellular aging processes damaging these systems were understood. Little is known about cellular and subcellular aging. The progress of modern biology has, however, provided methodology and concepts to investigate the processes involved. Because cellular aging underlies the aging of the whole organism, NICHD places special emphasis on this area of research.

Through tissue culture and transplantation studies, scientists have learned that normal mammalian cells cannot reproduce themselves indefinitely. This fact has caused a profound change in theories of aging by emphasizing that an understanding of organism aging may have to be based on cell biology.

The cell whose limited ability to reproduce itself has been most intensively studied to date is the fibroblast. This cell, similar to most dividing cells within the body, may provide a model for them. At the same time the fibroblast has its own importance as a producer of collagen and the mucopolysaccharides that constitute the structures providing mechanical support to other cells of the human body. NICHD is supporting research on many aspects of the limited reproductive po-

tential of fibroblasts, such as membrane, mitochondrial, and lysosomal function, protein and nucleic acid metabolism, peroxidation reactions, and hormonal responsiveness. It is hoped that these and other studies will disclose the mechanisms by which cell reproduction potential is limited and the consequence of this limitation or the effects leading to it. Such discoveries will be particularly important if they can be generalized to some other cells within the body.

MENTAL AGING

Knowledge of changes in the higher mental processes during the adult years is not complete since it is based mainly on comparisons between young and old persons. Since the younger persons have the better educational backgrounds these tests are likely to be biased in their favor. However, the results of such studies strongly suggest that there is deterioration in mental function with age. This deterioration is much more severe in non-verbal than in verbal abilities. The mechanism of this change is not known but may be related to progressive loss of brain cells that occurs with age. This decline in mental function does not incapacitate an individual and can only be detected by special tests.

Other, more serious, impairments of mental function may occur with aging. For many years, the severe cases of mental deterioration in the elderly were attributed to vascular disease. There is increasing evidence that this is not usually the case and that, in fact, most instances of such mental deterioration are due to changes in the brain cells produced by a special mechanism. The Institute is supporting studies aimed at determining and ameliorating these changes.

SOCIAL ASPECTS OF AGING

The average duration of life has changed tremendously since the evolutionary emergence of mankind, and there have been concomitant changes in the population age structure. There is no reason to think that these changes will not continue and that mankind will not continue to adjust to them.

Currently the average expectancy of life at birth in the United States is 71 years. Although there are a number of countries in Northern Europe with greater average life expectancies, the differences in terms of years are not great. In no area with good statistics does the average duration of life exceed 76 years. However, a maximum lifespan of 114 years or more is possible.

In the development of the future population characteristics of the United States changes in fertility rates and changes in mortality rates will play quite different roles. Once a society reaches a point where a large fraction of its women live through their reproductive years as the United States now has, then fertility rates can influence population size much more rapidly than can any reduction of mortality rates in the post-reproductive years. This is because sustained increases in fertility for generation after generation result in exponential growth which multiplies the population by some factor every generation. In contrast, any decrease in post-reproductive mortality influences population size by an appropriate factor only at that one time.

Since fertility rates may be lower in the future, whatever changes in post-reproductive rates that occur may assume more importance than in the past. For example, with zero population, current mortality rates, and no migration, this country would come to have 16 percent of its population over the age of 65 years. Zero population growth combined with the improvement of mortality rates that may come with the control of vascular disease and cancer could lead to a larger fraction of the population living past 65. For these reasons the Institute supports research to investigate the implications of changes in mortality rates for society and for the individuals who compose it.

It is, of course, impossible to predict future mortality rates. However, various assumptions can be made and their implications evaluated. The research currently supported is concerned with evaluation of mathematical models and the implications that can be drawn at this time. Although some idea of the range of possibilities has been obtained by investigating rather extreme assumptions, much more must be done before a comprehensive view of the possibilities facing society can be formulated.

THE GERONTOLOGY RESEARCH CENTER

The Gerontology Research Center (GRC) is the focal point for intramural aging research at the NIH. The 140 scientists, technicians, and supporting personnel at the Baltimore center investigate the biomedical, physiological, and

psychological aspects of aging in both humans and animals. An additional 10 projects in the guest scientist program involve 70 nongovernment personnel working projects related to aging or the health problems confronting the elderly.

New information gained this year ranged from man's continued ability to reason in old age to the fundamental mechanisms underlying many of the losses experienced by older organisms.

VIRAL PROTECTION OF OLD CELLS

One question asked by Center investigators is whether normal human cells lose the ability to protect themselves against viral infection when grown and aged in cultures. Normally full protection can be achieved by treating cells with specific compounds (polynucleotides) which stimulate the formation of interferon, a protective protein. Alternatively, the cells may be treated directly with interferon. Recent results reveal that the antiviral protection afforded by both agents decreases with the age of the cells and that old cells require larger amounts of protective agents. In contrast, once the cell is stimulated, the speed with which these substances are produced does not deteriorate with age. The findings suggest that the older cell's health might be maintained by developing more effective ways to stimulate protective protein production.

Viral infection of cells can also be used to test age-related deterioration of the cell's biochemical machinery. The replication of viruses within a cell requires many of these cellular components. Because viral replication continues to be effective in old cells as well as in young, some scientists conclude that a large part of the cellular machinery remains intact in old cells.

METAL IONS AND SENESCENCE

Minute amounts of metal ions such as copper, zinc, and magnesium are necessary for many biological processes and are present in all living tissues. The concentrations of these metal ions in cells are known to change with age. Therefore, it is important to know whether these changes cause errors in the cell's genetic message which in turn result in harmful cellular changes. Scientists at GRC have now shown that metal ions in concentrations only slightly higher than those essential to molecular genetic processes do generate significant errors. These errors include forcing interaction between the wrong kinds of cell components.

Related work in experimental animals is also being conducted.

PHYSIOLOGY AND AGING

Understanding complex mechanisms underlying "normal aging" is a crucial initial step toward unraveling the still more complicated connections between aging and disease.

Progress in this area was highlighted by several trends in the Baltimore Longitudinal Study data, and development of new testing methods for this study. The Longitudinal Study continues to be a most valuable resource for aging studies. It draws on a group of 600 community-dwelling volunteers, aged 20–96 years, who visit Baltimore periodically to take many physiological, biochemical, medical, and psychological tests to measure individual aging changes.

CHOLESTEROL AND TRIGLYCERIDE LEVELS

Serum cholesterol and triglyceride levels show strikingly different changes with aging in volunteers. Cholesterol is a substance found in almost all normal body tissue, blood, and bile. Excessive deposits of cholesterol in the walls of blood vessels are believed to produce one form of "hardening of the arteries," arteriosclerosis. Triglycerides are compounds which make up the fats and oils in human diets.

The research reveals that the serum cholesterol concentration increases in young and middle-aged men but levels off in later life. Triglyceride levels, on the other hand, remain constant in young men and fall significantly in middle-aged and older men. Through analyses of volunteer dietary habits, activities, and other variables, scientists are searching for the reasons why these age differences exist.

ULTRAVIOLET RADIATION AND AGE

Past studies of the effect of sunshine in producing skin cancers assumed that the damaging radiation spectrum was 290–320 millimicrons and that longer ultraviolet radiation wave lengths, 320–400 millimicrons, caused "tanning" and protected the skin against sun damage.

An investigator at GRC is studying the effects of age on sensitivity to ultraviolet light of different wave lengths and on the time course of these radiation effects. Preliminary findings show that longer ultraviolet wave lengths actually enhance skin sensitivity rather than having a protective effect.

REASONING ABILITY

Reasoning is one of the most prized behaviors of man. It is also one of the most elusive for experimental study. As part of the Baltimore Longitudinal Study, scientists are studying logical problem solving to assess age changes in the ability to reason.

HORMONES AND OLD CELLS

Laboratory techniques perfected recently suggest that the next frontier in basic biological research will be crossed with increases in understanding of the function and regulation of cellular membrane activity. Some of the causes of aging may be related to molecular events in these membranes. Scientists at GRC are conducting investigations to learn more about the mechanisms by which important cell constituents are transported across the membranes and the role of hormones in modifying the membrane, thus regulating cell function. There is already evidence suggesting that age-related changes do occur in these important cell components.

IMMUNITY AND AGE

Immunological studies at GRC have shown that the decline in immunity that occurs with age is the result of changes in the cells and their environment. There are two significant changes that occur: (1) a reduction in the number of parent immune cells; (2) a decrease in their ability to reproduce themselves and become efficient in producing antibodies (disease fighters).

In one recent study of aged mice, three investigators showed that aged stem cells in bone marrow have decreased ability to produce functionally effective B-cells (lymphocytes). The immune system is composed of B-cells, along with cells formed in the thymus gland (T-cells), and by acting together guard the body against infectious and other harmful agents.

Other investigations are underway to identify and characterize regulatory and precursor cells in order to determine their role in aging of the immune system. Additional studies search for ways to replenish defective immune systems in the aged and to control the diseases related to immune deficiency prevalent in the older population. These include diseases of the kidneys, joints, and blood vessels. One example is animal research testing the possible beneficial effects of caloric and protein restriction on the immune system.

GENETIC FACTORS IN IMMUNOLOGY

Genetic research focuses on metabolic and cellular changes associated with altered development and aging. Particular emphasis is on genetic factors that can influence human aging. To carry out these studies most efficiently, a tissue culture facility was established this year to grow, maintain, and store cells from young and old donors. Cell cultures have been initiated from minute skin samples of individuals with genetic disorders associated with accelerated aging. Emphasis is on the study of Down's syndrome (mongolism) a genetic disorder characterized by mental retardation and numerous other abnormalities. Individuals with Down's syndrome have lifespans averaging between 20 and 30 years. They are 10 times more prone to develop malignancies than the general population and have a high incidence of infections throughout life. In this genetic study, various biochemical methods are being used to describe cells from donors with Downs syndrome.

One study of men, aged 24 to 83 years, was begun in 1967 and completed during 1973. Initially, 300 men participated and 225 of these subjects were retested 6 years later. Comparisons of young and old men, based on their first performance, showed a systematic age-related decline in the proportion of men who successfully solved the first test problem (96 percent for men below age 40 and 73 percent for men over age 70).

The repeat studies showed there were definite age changes even for the select group of men who returned for second performance tests. For all age groups the proportion of subjects solving the problem in the second time was about the same as the proportion who solved it the first time. For subjects who solved the problem both times, age declines showed up only in men who were over 70 when tested originally.

Scientists plan to explore further physiological and behavioral measures available for subjects of the Longitudinal Study. Their eventual goal is to identify variables which relate to, and may underlie, the continued high reasoning ability seen in some older men.

ITEM 16. OFFICE OF EDUCATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
JANUARY 29, 1974.

DEAR MR. CHAIRMAN: Thank you for your letter of December 21 requesting reports on our activities in 1973 affecting the aging.

I am enclosing statements of such activities under the following Office of Education programs: Adult Education, Community Services and Continuing Education, Manpower Development and Training, Public Library Services.

Sincerely,

JOHN OTTINA,
U.S. Commissioner of Education.

[Enclosures]

ADULT EDUCATION

The adult education program authorized under the Adult Education Act of 1966, as amended, provides undereducated adults (persons 16 years of age and older) an opportunity to continue their education to at least the level of completion of secondary school and makes available the means to secure training that enable them to become more employable, productive, and responsible citizens.

The program is primarily a State grant operation administered by State education agencies according to State plans submitted to the U.S. Office of Education and approved by the U.S. Commissioner of Education. States are allowed grants to pay the Federal share of the cost of establishing or expanding adult basic education programs and adult education programs in local educational agencies and private nonprofit agencies. The matching requirement for the State grant program is 90 percent Federal funds and 10 percent State and/or local funds.

The fiscal year 1972 reports indicate the following age distribution of participants in the State grant adult education program:

Age group	Actual, fiscal year 1972	Estimate, fiscal year 1973
16 to 24	277,637	277,637
25 to 34	224,603	224,603
35 to 44	156,899	156,899
45 to 54	93,295	93,295
55 to 64	44,569	44,569
65 and over	23,405	23,405
Total	820,444	820,444

Public Law 93-29 amended the Adult Education Act by authorizing the Commissioner to make grants to State and local educational agencies or other public or private nonprofit agencies for programs to further the purpose of this Act by providing educational programs for elderly persons whose ability to speak and read the English language is limited and who live in an area with a culture different than their own. Such programs shall be designed to equip such elderly persons to deal successfully with the practical problems in their everyday life, including the making of purchases, meeting their transportation and housing needs, and complying with governmental requirements such as those for obtaining citizenship, public assistance and social security benefits, and housing.

However, to date no appropriations have been made to implement this section.

COMMUNITY SERVICE AND CONTINUING EDUCATION

The Community Service and Continuing Education Program, authorized by title I of the Higher Education Act of 1965, has supported a number of projects designed to assist the older American. During 1973 an estimated 8,000 persons in 12 States participated in 14 such projects. Activities included training programs for professional and paraprofessional staff of nursing homes; preretirement and retirement counseling; consumer education; and informational programs regarding Medicare/Medicaid benefits and housing assistance. Since funds appropriated for this program have been increased, 1974 will see an expansion of these efforts.

FACT SHEET: COMMUNITY SERVICE AND CONTINUING EDUCATION

PROGRAM OPERATION

Title I of the Higher Education Act of 1965 (Public Law 89-329, as amended) authorizes grants to the 50 States, the District of Columbia, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Virgin Islands. The intent of these grants is to strengthen the community service programs of colleges and universities for the purpose of assisting in the solution of community problems. The program is administered in each State by an agency designated by the Governor, under a State Plan approved by the U.S. Commissioner of Education. The State agency establishes program priorities and approves and funds institutional proposals. Funds are provided on a 66⅔ Federal and 33⅓ non-Federal basis. A community service project under this Act means an educational program, activity or service, including research programs and university extension or continuing education offerings.

Section 106, title I, of the Education Amendments of 1972 (Public Law 92-318) amended title I HEA to authorize the Commissioner to reserve 10 percent of the sums appropriated in order to make awards to institutions of higher education, or combination of these institutions, to assist them in carrying out special projects which are designed to seek solutions to "national and regional problems relating to technological and social changes and environmental pollution." It has been determined that program activities will be limited to demonstration or experimental efforts. Projects must be based on a design for and the implementation of organized continuing education activity for adults.

Title VIII of the Older Americans Comprehensive Services Amendments of 1973 further amended title I HEA to authorize the Commissioner to make grants to institutions of higher education to assist them in carrying out programs specifically designed to apply the resources of higher education to the problems of the elderly, particularly with regard to transportation and housing problems of elderly persons living in rural and isolated areas. For the purpose of making these grants the Act authorized to be appropriated "such sums as may be necessary."

FUNDING

Congress determines the appropriations annually. Of the sums appropriated the Commissioner may reserve 10 percent for special project discretionary grants, and allot $25,000 each to Guam, American Samoa, Puerto Rico, and the Virgin Islands and $100,000 to each of the States and the District of Columbia. The remainder is distributed on a population ratio basis. Total appropriations for fiscal year 1974: $15 million.

Funds have not been appropriated for section 110 of the Act which authorizes special programs related specifically to the problems of the elderly.

For Further Information

Contact the Community Service and Continuing Education Program, Bureau of Post-Secondary Education, U.S. Office of Education, Washington, D.C. 20202.

MANPOWER DEVELOPMENT AND TRAINING PROGRAM (PUBLIC LAW 87–415, AS AMENDED)

Although occupational programs for persons over 45 have been available since the inception of the Manpower Development and Training Act of 1962, the 1966 amendments recognized the special requirements of the older worker in areas of training and employment.

In fiscal year 1973, participation of older workers in the MDTA program continued at a somewhat lower level than the previous year, with persons 45 years of age and older representing 7.4 percent of the total enrollment. Following is the report of participation for both institutional and on-the-job training for fiscal year 1973:

	Total	Institutional	On-job training
Enrolled	195,200	119,600	75,600
45 years or older	14,413	8,970	5,443
Percent 45 years or older	7.4	7.5	7.2

PUBLIC LIBRARY SERVICES

Office of Education support for library and information services for the aging during 1973 included a variety of activities ranging from talking bookmobile services to development and implementation of services to the institutionalized. The projects have been funded primarily by the Library Services and Construction Act (LSCA) and the Higher Education Act of 1965, title II–B.

Emphasis on the concern for the older American has been shown by the efforts to study the information needs of the aging, identify those persons who constitute the population segment for which these services may be appropriate, and the design of programs which will be effective and useful to this target group. In a national study, conducted in 1973 and supported by LSCA, it was learned that the elderly reader represents one of the highest user groups of public library services. The older patron shares the concern for improvement of library and information services with these suggestions: (1) the services should be more accessible; (2) transportation should be provided for older patrons; and (3) books and materials should be delivered to the neighborhood.

A survey of the literature (supported by a HEA, II–B demonstration grant—completed in 1973) describes the information needs of the disadvantaged and includes the following comment:

> "Due to the depleted financial resources, the Aging American is forced to rely more on public programs for life support . . . There is a critical need for information services that will dispense information on the various social agencies and their programs in an agressive manner . . . "

Older Americans in significant numbers participate in programs specifically designed for the physically handicapped. Both the LSCA and the Library of Congress Program for the Physically Handicapped include large numbers of elderly handicapped persons; they account for a major portion of readers of talking books, braille and other special reading materials available on loan through a network of 52 regional and subregional libraries for the blind and physically handicapped throughout the country.

Librarians seek to involve older persons by direct visits to shut-ins; books by mail; telephone information services; free telephone services to Regional Libraries for the Handicapped; group programs (films on travel, consumer education, and other subjects, lectures, demonstrations, discussions, concerts, art

exhibits, crafts, hobby shows, etc.); employment programs; and free transportation to the libraries.

LSCA funds are used to develop programs to identify eligible readers and acquaint them with available services; to buy large print materials, commercially recorded materials and reading aids; conduct programs for recording materials in Indian, Spanish, Canadian-French, Polynesian and other native languages, and for staff and equipment. In Arizona, for example, the Easter Seal Society and the Desert Regional Library jointly operate a talking bookmobile throughout the State to promote talking books and enroll new borrowers—elderly readers are the principal patrons.

Future plans for library and information services for the aging include the refinement and implementation of model programs developed during the year and continuation of established services and programs. The 1973 amendments to the Older Americans Act include opportunities for strengthening library services to older adults. Until such time as the "Older Reader Services" amendment is funded, assistance will continue from the general service of the Library Services and Construction Act, title I.

ITEM 17. OFFICE OF NURSING HOME AFFAIRS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
PUBLIC HEALTH SERVICE,
January 24, 1974.

DEAR MR. CHAIRMAN: In preparing your report on the activities on the aging, requested by your letter of December 21, we have concentrated on those elements related to the implementation of the President's Nursing Home Initiatives and Public Law 92-603 that are the direct concern of the Officer of Nursing Home Affairs. There are a number of other activities and programs within the Department that contribute to the improved health care of the aged which we did not attempt to summarize because they will be reported elsewhere.

In this report we have attempted to highlight major activities and accomplishments for 1973 and to outline program directions for 1974. With the publication of the final regulations for skilled nursing facilities and intermediate care facilities in the January 17 Federal Register, we have now moved into a new phase of the Department's efforts to assure quality nursing home care for the elderly.

We appreciate the opportunity to provide this report to you. If you have any questions or wish further information on any of the areas discussed, please do not hesitate to get in touch with me.

Sincerely,

FAYE G. ABDELLAH,
Assistant Surgeon General, Chief Nurse Officer, PHS, and Director, Office of Nursing Home Affairs/PHS.

[Enclosure]

IMPLEMENTATION OF PRESIDENT'S NURSING HOME INITIATIVES

ANNUAL REPORT—1973

BACKGROUND

The thrust of the Office of Nursing Home Affairs in 1973 was to continue to coordinate the overall Department of Health, Education, and Welfare's programs and efforts toward nursing home and long-term care improvement in this country. This office has worked closely with the regional offices, as well as with the various agencies concerned at the national and regional levels. Among the DHEW agencies involved in this coordinated effort have been the following: Bureau of Quality Assurance, Health Services Administration; National Center for Health Statistics, Health Resources Administration; Bureau of Health Services Research, HRA; National Institute of Mental Health, Alcohol, Drug Abuse and Mental Health Administration; Administration on Aging, Office of the Assistant Secretary for Human Development; Office of Facilities Engineering and Property Management, Office of the Secretary; Bureau of Health Insurance, Social Security Administration; and Medical Services Administration, Social and Re-

habilitation Service. Other Federal agencies involved have been the Department of Housing and Urban Development and the Veterans Administration.

Major efforts in this last year have included: Enforcement of standards, implementation of the Life Safety Code, development of new standards, surveyor training, provision of technical assistance and provider training, research and development, consumer and provider liaison, and development and utilization of data systems.

NOTE.—HRA, HSA and ADAMHA derived in late 1973 from the former Health Services and Mental Health Administration.

STANDARD DEVELOPMENTS

New standards

A new single set of regulations to cover skilled nursing facilities (SNF's) (formerly extended care facilities under Medicare and skilled nursing homes under Medicaid), as mandated on passage of the Social Security Amendments of 1972 (Public Law 92–603), was published under notice of proposed rulemaking in the July 12, 1973, Federal Register. This document was prepared, under coordination by the Office of Nursing Home Affairs, by an interagency work group from the Bureau of Quality Assurance, Health Services Administration; Bureau of Health Insurance, Social Security Administration, and the Medical Services Administration, SRS. Early in this process, all national health-related professional organizations and other Federal agencies were consulted about the proposed revisions as they relate to their special interests. Sixty days were permitted for public comment on the published document, resulting in hundreds of letters from health-related professional organizations, public interest and patient advocacy groups, and individuals—all of which were reviewed in detail. Also reviewed and responded to in detail were recommendations received through special hearings on trends in long-term care of the U.S. Senate Special Committee on Aging before the Subcommittee on Long-Term Care on October 10 and 11, 1973.

BQA staff worked closely with BHI over several years in updating and revising the Medicare regulations for home health agencies, which were published under notice of proposed rulemaking in the September 18, 1971, Federal Register. Following extensive work to coordinate the format and language in the document with those adopted in the meantime in revision of other provider regulations, final conditions of participation for home health agencies were published in the July 16, 1973, Federal Register. In addition, staff served in a consultant capacity to MSA in its recent development of regulations for home health services under Medicaid.

At the request of MSA and ONHA, and under ONHA's direction, BQA assisted MSA in developing new regulations for intermediate care facilities, a new category of provider institution in the Medicaid program, created by an act of Congress in 1971.

ONHA had conferences with a number of provider and citizen groups to receive and discuss their concerns for both SNF and ICF requirements.

Enforcement of standards

In an initial survery made in 1972, the Office of the Assistant Secretary for Health assisted SSA and SRS in insuring that States had the necessary administrative mechanisms to survey and certify nursing homes and that all title XIX homes were properly certified. As a result, over 500 nursing home agreements were terminated for not meeting Federal standards. This survey provided a basis for further monitoring for State agency certification activities. As a result of Public Law 92–603, a single State agency must conduct these surveys of both title XVIII and XIX homes, further strengthening the process.

Regional directors have been delegated the responsibility for survey and certification for long-term care facilities in their regions, specifically, for enforcement of all title XVIII and title XIX SNF/ICF regulations. They also have authority for termination and approval of provided agreements under title XVIII, as well as authority to approve waivers of the Life Safety Code under title XIX.

Implementation of New SNF and ICF Regulations

A single statement of standards for SNF's for title XVIII and for new standards for ICF's were published in the Federal Register on January 17, 1974. Guidelines for implementation are being developed, and orientation workshops are being planned in conjunction with BQA, BHI and MSA to provide con-

tinued technical assistance to the regional offices and State agencies in carrying out their responsibilities.

As a result of public comments, several new requirements are being proposed for addition to the conditions of participation for skilled nursing facilities, i.e., medical direction, extended registered nurse coverage, discharge planning, and protection of patients' rights, through a later issuance of notice of proposed rulemaking in the Federal Register.

The Office of Nursing Home Affairs was established to provide a departmental focal point for standards enforcement and facility improvement activities. Meetings with the regional directors' long-term care coordinators will be held several times this year to promote regional office/central office coordination in this area.

LIFE SAFETY CODE

A major effort was initiated by ONHA during 1973, aimed at improving the enforcement of Life Safety Code requirements. Baseline data from certification files were obtained and analyzed. State enforcement programs were assessed and State surveys were checked on a sample basis. The baseline data gathered will assist the Regional Directors in assuming their responsibility for approving and terminating agreements with title XVIII skilled nursing facilities and for approving waivers of life Safety Code requirements for all SNF's.

Also in 1973, courses for approximately 600 State fire safety surveyors were held, with the assistance of the National Fire Protection Association. Departmental workshops have been held on the application of life Safety Code requirements and documentation of findings.

Now that the Life Safety Code survey initiated by ONHA has been completed and results forwarded to the regional directors, ONHA will attempt to improve compliance by requiring the regions to submit quarterly reports on these activities.

Another major effort in fiscal year 1974 will be in surveying intermediate care facilities to insure that they comply or will be able to comply with Life Safety Code requirements.

The President recently signed S. 513 into law (Public Law 93-204), authorizing the Secretary of the Department of Housing and Urban Development to make commitments to insure loans made by financial institutions or other approved mortgages to nursing homes and intermediate care facilities to provide for the purchase and installation of fire safety equipment necessary for compliance with the 1967 edition of the Life Safety Code of the National Fire Protection Association or other such codes or requirements approved by the Secretary of DHEW as conditions of participation for providers of services under titles XVIII and XIX. The Director of ONHA is chairing an HEW/HUD task force to develop an interagency agreement to make the program operational by March 1, 1974.

SURVEYOR TRAINING

The Health Facility Surveyor Improvement Program, a comprehensive and ongoing activity, was instituted in 1970 to improve the interpretation and uniform application of Federal health care standards by State agency personnel through training and evaluation of individual surveyor performance. It's primary objective is to support and strengthen the certification process by ensuring that those individuals responsible for its administration have the skills and knowledge necessary for them to function effectively. These university based courses have provided career ladders for health facility surveyors through basic, advanced and supervisory courses. By the end of December, 1819 State and Federal personnel, representing all disciplines associated with nursing homes, had been trained.

Surveyor Inventories have been made at regular intervals since 1969 to more clearly define the surveyor population and its needs.

HSFIP coordinators have been functioning as effective focal points in each region since 1969.

A major goal of this program for the coming months will be to conduct a comprehensive evaluation of surveyor training activities. This will include evaluation of current training programs, assessment of skills and knowledge needed at various levels of the surveyor career ladder, and a recommended training model to fill the training needs thus identified. This will allow for a regional reevaluation of the goals and priorities of HFSIP and permit redesign of the in-

tegrated surveyor training program as necessary to fill the provider certification needs identified in the evaluation.

Courses will continue for new surveyors and to update those presently employed, with specific emphasis on Life Safety Code requirements of the new SNF and ICF regulations. Specialized training, such as in provider consultation, will be offered in 1974. It is estimated that 350 additional surveyor personnel will attend courses in fiscal year 1974.

Contracts are being developed for training personnel in the development and management of Professional Standards Review (PSRO) in response to Public Law 92-603. Regional focal points have recently been named.

A new Surveyor Inventory, for completion in fiscal year 1974, is underway and will complement a State personnel profile currently being developed by BQA and BHI.

TRAINING AND TECHNICAL ASSISTANCE

(BUREAU OF HEALTH SERVICES RESEARCH, HRA)

In July 1973, a reorganization abolished the Health Services and Mental Health Administration and created in its stead the Health Resources Administration and the Health Services Administration. A division of long-term care was created in the Bureau of Health Services Research of the Health Resources Administration. Specific functions transferred to the division include long-term care research and development activities previously carried out by the former National Center for Health Services Research and Development. It also included those activities conducted by the former Community Health Service that were designed to improve the quality of care in ambulatory and home health services and in nursing homes through consultation, technical assistance and training directed to upgrading the performance of long-term care personnel, and through creation of new services that incorporate innovative concepts. Following passage of Public Law 92-603, the division was also given lead responsibility in the development of demonstrations and experiments to test the proposed new options relating to reimbursement under Medicare and Medicaid for long-term care through use of intermediate care facilities, homemaker services, and day care.

The Long-Term Care for the Elderly Research Review and Advisory Committee continued to serve as a formal grant review panel and, on an ad-hoc basis, continued to assist in the review of outcomes emerging from ongoing projects. In addition, the document entitled "Long-Term Care of the Elderly: A Research Strategy," prepared by the committee and staff served as the basis for on-going planning and discussion.

In continuing to implement the President's Nursing Home Improvement Initiative of 1971, training activities were developed in 1973 through short-term contract efforts at the national and State levels.

Contracts provided for a wide range of training approaches and were designed to demonstrate the value of new methodologies. All categories and levels of nursing home personnel were trained through these programs.

Contracts were awarded to five national organizations to provide: (1) Training for social work designees and consultants to meet the human and social needs of long-term care facility patients; (2) geriatric training for licensed practical nurses and licensed vocational nurses employed in nursing homes; (3) pharmacy training for nursing homes; (4) continuing education on social components in long term care facilities; and (5) development of training materials for reality orientation therapy.

Five State-based contracts were awarded, designed to supplement other training activities for nursing home personnel within the States of California, Colorado, Mississippi, Utah, and Washington.

A new approach was initiated based on the concept of a nationwide long-term care education system with six contracts. These regional centers are training provider personnel in their respective geographic areas. The training centers will utilize career ladder concepts and involve a broad range of innovative teaching techniques to be provided at all academic levels—commencing at the high school level and using local educational institutions, including community colleges.

Also in fiscal year 1973, program areas of special emphasis were initiated. Specifically, six purchase orders were developed to ascertain the problems of minority clientele and providers in upgrading the quality of care in nursing homes serving predominantly minority groups.

The division of long-term care's training efforts have resulted in the training of 14,485 long-term care provider personnel. Of this number, 2,074 were trained through national organization contract efforts, 2,237 through State contracts, with the remaining number trained through Regional Office involvement with State and local organizations. A total of 183 courses were offered with content including, but not limited to, pharmacy, medical records, administration, nursing services, housekeeping, dietetics, inservice education, social work, and physical therapy.

To coordinate these efforts in the regional offices, long-term care education coordinators have been functioning effectively in each region.

In fiscal year 1974, training activities will continue through the use of short-term contracts and purchase orders at national, regional and State levels.

Specifically, a new approach to training based on the concept of a nation-wide long term care education system using long-term care institutions as settings for training, will be expanded to include the remaining four DHEW regions (IV, V, VII, X). These regional centers will not only provide direct training opportunities for personnel in their geographic areas but will help them develop their own capability to continue provision of that training on a fee-for-training basis when Federal funds are discontinued.

Fiscal year 1974 plans also call for completion of the cycle of utilization of national professional organizations to conduct training programs designed to upgrade care in the Nation's nursing homes. This plan will involve the American Dietetic Association (dietitian and food service supervisor) and the American Medical Record Associates (medical record clerks and librarians). The plan will also include a followup to the AMA training contract of fiscal year 1972 which will involve State medical associations in provision of training in the "role of the medical director." This is of special significance in light of recent Federal regulations which will require skilled nursing facilities to employ a medical director.

The rural nurse aide has also been designated as an area of program emphasis in fiscal year 1974. Specifically, we plan to support several (3–4) rural State nursing home or professional associations in sponsoring short-term training activities for nurses aides employed in nursing homes in rural areas, because most training opportunities are offered in large urban areas and are therefore out of reach for most rural-based nurses' aides.

On the basis of our fiscal year 1973 feedback regarding its positive impact, our fiscal year 1974 plan calls for continuation of Regional Office allocations to assist them in meeting educational needs in their respective areas.

Areas of special interest for program development in fiscal year 1974 include establishment of a long-term care media center which will serve as a central repository for the training and educational materials developed through contract so that these materials will be more readily available to providers throughout the country. Another priority area involves a plan to evaluate the training contracts impact on the attitudes, skill, development and behavior of the special training and educational needs of minority nursing home clientele and providers in upgrading quality of care.

To date, in fiscal year 1974 (July 1 to November) 10,759 provider personnel received training. Of this number, 120 received training through national professional organization contract efforts, 3,109 through State-based contracts with the remaining number 7,530 trained under Regional Office auspices. Over 107 courses have been offered in such fields as nursing, pharmacy, social work, dietry, housekeeping activities, and reality orientation. Short-term training for nursing home personnel, established as a keystone in the Federal effort to upgrade nursing home care, will continue.

TRAINING AND TECHNICAL ASSISTANCE
(NATIONAL INSTITUTE OF MENTAL HEALTH, ADAMHA)

The National Institute of Mental Health has also instituted a strategy of program development for short-term training in the mental health aspects of long-term care. It is based on several general principles which, although commonly accepted in the mental health and continuing education fields, requires demonstration in the long-term care field. An underlying assumption, or operational philosophy, is that a vast amount of experience and resources are available in the Nation; and the task is to effectively link these resources to meet

the training needs at hand. NIMH's immediate goal is to demonstrate a variety of linkages of mental health, continuing education, and long-term care resources to increase knowledge and skills of caregivers to improve the psychosocial aspects of caregiving, thus improving the quality of life of long-term care facility residents.

In June 1972, five training contracts were negotiated to demonstrate a variety of models of linkages between long-term care facilities, mental health agencies, and continuing education programs. In June 1973, three of these contracts were renewed for fiscal year 1974, and an additional contract was negotiated to demonstrate the role of the community college as the continuing education link, especially in a rural setting.

In September 1973, a followup conference to the May 1972 conference was held, bringing together two representatives each of national professional organizations which have member/practitioners in the long-term care field. The purposes of the conference were to identify the mental health aspects of professional practice that are common to all the organizations and to stimulate increased attention to mental health continuing education programs within and among the disciplines.

In fiscal year 1973, NIMH regional consultants concentrated on identifying needs and capabilities within the States and regions they serve. (Each consultant serves two regions.) During June to December 1973, consultants provided technical assistance to State and community agencies and facilities, and have implemented training activities in States, providing consultation and using the purchase order mechanism to provide financial assistance as appropriate. In many instances, the NIMH and the long-term care education regional coordinators have collaborated in program development and support activities in order to maximize limited resources. In June 1973, NIMH participated in the review of proposals from several regions for the establishment of regional training centers and subsequently jointly funded four centers. Regional NIMH consultants will assist the long-term care coordinators in monitoring the contracts and in providing technical assistance to the several centers.

As a part of the Regional Office strategy for 1974, Mental Health Program Development Conferences are being planned as a mechanism for bringing together appropriate regional, State, and local personnel to explore needs in a given service delivery area for purposes of discussing and mapping out strategies for meeting defined needs.

As the State mental hospitals increase their utilization of nursing homes and related long-term care facilities as community-based placements for discharged patients, increased attention will be given to involving the State mental health agencies in direct training activities for long-term care personnel. NIMH will play a key role in strengthening the linkage between psychiatric treatment facilities, especially State hospitals and nursing homes to: (1) Increase the capability of nursing homes to receive and adequately meet the needs of mentally ill persons; and (2) improve the referral mechanisms between these two types of facilities. Involvement in this area will be a major activity of the regional consultants for this year and next.

In addition to utilizing the Mental Health Program Development Conference mechanism to strengthen Regional Office capability, the Nursing Home Improvement Consultant and the Associate Regional Health Administrator for Mental Health may use funds, at their discretion, to support activities which are unique to program development needs of the region or an individual State and directly related to the Nursing Home Improvement Program.

A new element being introduced to the short-term training strategy is the development of training aids and materials. Two major activities are currently underway, one jointly supported by HRA and NIMH. A contract with the American Hospital Association is underway (negotiated in the spring of 1973) to prepare audiovisual-programed materials for reality orientation training. During the spring of 1974, NIMH will issue a request for proposal for a training film based on the manual "It Can't Be Home," DHEW Publication No. HSM 71-9050. This publication is designed as a guide for assessing the dimensions and components of residential care which enhance the fulfillment of the residents' physical, social, and emotional needs.

The Division of Manpower and Training, NIMH, is undergoing a redefinition of mission and a redirection of program thrusts to provide a closer linkage of training programs to the service delivery systems. Funds will be reprogramed

for more broad-based manpower development activities as opposed to discipline-specific long-term training program support.

The NIMH program development goal will be to more closely integrate the Nursing Home Improvement Program into the overall mental health manpower development strategy, at the State, regional and headquarters levels. Specific project funds will be utilized to support projects designed to develop or strengthen the capacity of the long-term care service delivery systems to meet their own training needs. A major staff activity will be to provide consultation and technical assistance to the field, utilizing the knowledge and experience gained from the demonstration projects.

RESEARCH AND DEVELOPMENT

Through contracts and grants, studies are being conducted by the division of long-term care in the broad areas of: (1) Quality of care; (2) assessment of alternatives to institutional care; and (3) data collection.

Quality of Care

Projects funded to study the quality of care include a project conducted by Rush-Presbyterian-St. Lukes Medical Center in Chicago. Entitled "Objective Scales for Measurement of Quality Care and Life in Nursing Homes and Other Long-Term Care Facilities," this project has assembled and pilot tested objective scales of patient needs, institutional environment and patient placement in the long-term care field in order to assess their validity and reliability. The final instruments and the resulting quality construct should prove to be effective tools for use in the regulatory mode by surveyors to ascertain the quality of care provided by a given institution based on the needs of its patient population.

A project at Harvard will develop and demonstrate a system for assessing the status of patients in long-term care facilities using as a basis the classification instrument produced under a previous NCHS R&D grant. The same classification instrument is being utilized at Johns Hopkins to determine patient profiles, assess patient care needs and develop the protocol for producing care plans. Guidelines for review of the appropriations and extent of services provided will be developed from the comparison of these care plans with observed patterns of services. The guidelines will then be tested for applicability for Professional Standards Review Organization use.

A grant with Michigan State University is developing outcome measurement indices to be used in experiments and demonstrations to be conducted under Section 222 of Public Law 92–603, dealing with day care services, homemaker services and intermediate care facilities.

Alternatives to Institutional Care

Efforts in carrying out the tasks for developing alternatives to institutionalization in 1973 progressed along three avenues; sponsorship of extramural demonstrations and evaluation projects; intramural staff effort in review of the literature and summarization of expert opinion; and particularly in the areas of home care and day care, technical assistance to other Federal programs and to public and private agencies and organizations concerned with these subject areas. A project awarded to the Commonwealth of Massachusetts has been designed to test whether social and other support services can provide a more desirable setting for the patient and a less costly alternative to institutionalization for elderly and disabled adults. Support for this project was also provided by the Administration on Aging. Other projects jointly funded with the Administration on Aging include those which focused on specialized boarding homes, surrogate families, and alternative systems of care for the aged.

Expert opinion was obtained at a workshop in alternatives to institutional care undertaken by the Long-Term Care for the Elderly Research Review and Advisory Committee.

Work relating to development of the proposal designed to test the feasibility and cost effectiveness of the options for intermediate care, homemaker and day care services, as called for in section 222 of Public Law 92–603, included development of state of the art papers on the three component services, development of a research plan, and drafting of a request for proposal. Assistance to division staff in reviewing and extending the work was provided by a coordinating and technical work group comprised of representatives of the Office

of Policy Analysis and Research, Office of Nursing Home Affairs, Bureau of Quality Assurance (HSA), Social Security Administration, Social and Rehabilitation Service, Administration on Aging, and the Alcohol, Drug Abuse and Mental Health Administration, as well as selected Division staff.

In an effort to obtain definitive information on the current status of day care, a purchase order was negotiated with Levindale Research Center to conduct and in-depth programatic review of selected day care centers, and to analyze and interpret the findings, with emphasis on implications for national policy.

Data collection, R&D

As a followup to the successful Illinois statewide automated system for regulation and medical review of long-term care facilities and patients developed through a 1972 contract, a contract was awarded in 1973 to the State of Illinois to provide technical assistance to the other States in the region that are interested in learning more about the Illinois system. The cost of actual implementation, if desired, is to be provided by the respective States.

Completed in 1973 was a national directory of homemaker-home health aide services, identifying approximately 1,800 organizations that provide such personnel.

Another project, currently being conducted by the Iowa Hospital Association, is geared toward the development of a uniform data system for long-term care patients and institutions that will permit effective planning, management and licensing of long-term care services, to be followed by a determination of the feasibility of implementing collection of long-term care data on a statewide basis.

Other

A project to develop a National Center for Aging and Aged Blacks in Washington, D.C., was jointly funded by the division and the Administration on Aging. Conducted under the auspices of the National Caucus on Black Aged, this project is concerned with all research and development interests, but places particular emphasis on collecting data relating to health status of and health services for the black aged. It is anticipated that knowledge gained from comprehensive review of ongoing research and support of new research will provide a sound basis for program planning for this segment of the population. All health and health-related activities of this Center will be of interest to the division, and division staff will be available to the center to provide technical consultation.

Of particular interest to the staff and extremely important to the work of the division is the Bureau-funded project entitled "Review and Analysis of Long-Term Care Literature: Implications for Planning, Action and Research." The results of which are currently being published.

In addition to work carried out in the division of long-term care, the staff was involved in activities carried out in other components of the Bureau of Health Services Research. The staff will continue to work collaboratively with other concerned departmental components and other Federal agencies in identifying research needs, utilizing research findings, and in joint funding of research and demonstration endeavors. Technical assistance will be provided to national and professional organizations and State agencies and to providers involving evaluation efforts related to long-term care. In continuing to respond to Presidential initiatives and national priorities associated with long-term care, ongoing projects will be redirected as needed to sharpen the focus and maximize the potential of the products for broad application. New projects will, as funding resources permit, help to fill remaining gaps.

After years of national concern and debate, the needs of the long-term patient remain a major unsolved problem in the delivery of health care services in this country. Neither care institutions, financing mechanisms, orientation of health professionals, nor thrust of health planning have adjusted to the replacement of acute illness by chronic disease as the major national health priority. The approach of the Long-Term Care Program for fiscal year 1974 is to seek an effective interface between the expanded government roles in financing (made possible through Public Law 92–223 and Public Law 92–603) and in assuring quality of care (given impetus by the President's Nursing Home Improvement Program).

Program plans for the coming year include both intramural and extramural research, experiments, and technical assistance directed toward the development and evaluation of innovative approaches to improve the quality of life

and quality of care for the elderly and/or disabled who require long-term services. When models and prototypes have been tested staff will assist in implementation of effective models in practice settings.

Emphasis will be placed on:

Measuring the quality of care, including the development of instruments to ensure that the most appropriate level of care is being provided;

Offering consumers and the public mechanisms to insure a greater and more knowledgeable voice in demanding quality of care and increased options for care;

Upgrading the skills of health workers associated with long-term care through developing and testing training courses and materials; and

Improving coordinating mechanisms for increasing the options of patients for receiving needed care in the appropriate setting through a balanced array of institutional, ambulatory and home health services, including improved administration and management procedures.

Specific areas of concentration in 1974 include intensified activity in relation to implementation of section 222 of Public Law 92-603 in developing demonstrations to determine cost effectiveness of day care, homemaker service and intermediate care, further testing of the collaborative patient assessment instrument, development of a cost data reporting system for nursing home care, exporting a uniform basic data set for long-term care to other States in Region V, evaluation of the feasibility and impact on quality of the use of indices of quality of care in nursing homes.

Specific areas in which the staff in the Division of Long-Term Care will collaborate with other components of the Bureau include: credentialing of paraprofessional personnel in long-term care facilities including mechanisms for regulating these personnel and the effects on the quality and costs of care, outpatient care for children with cancer, extension of Experimental Health Services Delivery Systems, development of a system for classification and appropriate placement of patients, evaluation of the different hospital, boarding home, artificial families and alternative service delivery systems.

The research and demonstration efforts will focus on developing mechanisms and instruments for patient assessment to improve decision-making regarding placement, continuity and appropriateness of care; assessment of quality of care being provided; and assessing cost/effectiveness of alternative methods of care. To be emphasized will be the expansion of the nursing home data base, linking it to data regarding home health care and other parts of the health system and related resources.

It is hoped that these comprehensive efforts will strengthen the position of the Bureau and HRA in making recommendations to ONHA and the Assistant Secretary for Health about policy and strategies related to increased benefits, broader options for quality care at contained cost, and opportunities for participation by long-term care patients.

NURSING HOME DATA SURVEY

A national sample survey for nursing home data collection was instituted by the National Center for Health Statistics in January 1973. In early 1973, a contractor was selected and work began on interviewer training materials. Field work was initiated in 100 nursing homes in eight large metropolitan areas. Questionnaires were developed, data processing began and training materials were modified before midyear 1973. In the summer, sampling specifications for staff and patients were completed. After 2,112 nursing homes were selected for the national survey, the actual interviewer training began in 27 cities; and the field work was done through interviewing of 20,000 patients. This survey, to be completed in 1974, will provide heretofore unavailable data on services, patients, staff and costs. A second survey will be conducted at a later time.

CONSUMER AND PROVIDER RELATIONS

Under Public Law 92-603, the Department of Health, Education, and Welfare, particularly through the Social Security Administration, began implementing the pertinent activity of public disclosure on nursing home activities. Survey reports on nursing homes were received by Social Security district offices, who received requests for the information from the public.

In the process of implementing the Nursing Home Improvement Program in the last year, ONHA had liaison with many consumer and provider organiza-

tions. The office met with several of these groups to discuss issues of mutual interest. Regulations, agency responsibilities, provider responsibilities, and consumer interests were addressed. Office staff participated in annual meetings and other conferences of such groups as the American Association of Homes for the Aging, the American Nursing Home Association, the American College of Nursing Home Administrators, the American Medical Association, and the American Nurses Association. Among the consumer groups met with at their request, and principally related to because of their concerns, were the American Association of Retired Persons/National Association of Retired Persons and the National Council of Senior Citizens. The office has continued to emphasize the critical aspect of positive and constructive dialogue with both consumer and provider groups.

As the departmental focal point on long-term care for the relationships with outside organizations and agencies, ONHA plans to have ongoing communications with a number of consumer and provider groups and to develop a consumer/provider advisory conference. This will allow for the exchange of ideas for the identification of problems and the achievement of possible solutions through modification of Federal programs or regulations. In these ways, the Federal Government can continue to make good its commitments to make nursing home care more humanized as well as cost-effective and to develop alternative resources so that the chronically disabled and elderly can be well served by the Nation's health care delivery systems.

Ombudsman

The five nursing home ombudsman demonstration projects, contracted in June 1972, to test approaches to providing a voice for patients in nursing homes, successfully completed all developmental tasks and were fully operational at the end of one year. Publicity campaigns resulted in projects becoming well known in their target areas.

All projects received, investigated and resolved complaints. It is premature to analyze fully the number and types of complaints received and the methods of resolution.

However, some interesting patterns have begun to emerge. During the first year of partial operations, the five demonstration projects received a total of 1,196 individual complaints from 713 complainants. Most cases involved more than one complaint or problem. Most of the complaints were made by a friend or relative on behalf of the patient.

In each of the projects, between 50 and 60 percent of the complaints were concerned with the quality of care provided in the home, with the rules and regulations or administrative policies of the home, and with payment for care. Contrary to popular expectations, a relatively small number of complaints were about (7 percent). More than 80 percent of the complaints or problems were verified or justified; that is, in the judgment of the ombudsmen and their consultants, the reported incidents or problems reflected complaints that could or should be corrected.

Based on patterns that have emerged from cases investigated by the ombudsmen and on special studies conducted by the projects and their advisory groups, a number of significant and broad problem areas were pinpointed for action in the second year of demonstration. The following items are a sample of the issues to be addressed: overuse of tranquilizers, lack of community ties, inadequate physician care, inappropriate placement of patients, life-care contracts, lack of coordination of standards, excessive charges, lack of alternatives to institutional long-term care, and need for training of nursing home staff.

Contracts with Idaho, Pennsylvania, South Carolina, Wisconsin, and the National Council of Senior Citizens have been renewed for a second year of demonstrations. In addition, on June 30, 1973, 1 year contracts were let to Oregon and Massachusetts, expanding the program to seven projects.

Responsibility for the nursing home ombudsman demonstration project contracts has been transferred to the Administration on Aging, as a part of that agency's involvement in long-term care programs. During the coming year, ONHA will have continued interest and will participate in the monitoring of this activity.

STRATEGY

The thrust of the overall departmental long-term care effort is, and will continue to be, the implementation of the President's eight-point Nursing Home Improvement Program, new requirements of Public Law 92-603, and achievement of basic improvements in the long-term care delivery system. With the publication of single Federal regulations for skilled nursing facilities and the new Federal regulations for intermediate care facilities, the task of ensuring the efficient and consistent application of these regulations becomes a high priority for the Department and the State agencies. Specific delegations of responsibility have been made to both ONHA and the regional directors to facilitate the carrying out of these responsibilities. ONHA has the responsibility for short-term policy development on all issues concerning long-term care, with particular responsibility for conceptualizing, developing and monitoring short-term policy options and for long-term care issues and for consistent application of policy throughout the regional offices. Regional directors have responsibility for the implementation of the long-term care effort within their region. High priority of ONHA is to establish mechanisms which will allow it to monitor and evaluate the operational efforts related to long-term care in SRS and SSA, as well as the health agencies in the regional offices. A regional office long-term care objective is being developed which will serve to make more visible and better integrate various aspects of long-term care activities underway in the regions. This will also serve to put into place the resources, organization and procedures needed for the implementation of the SNF and ICF regulations and enforcement of the Life Safety Code. A major continued activity of ONHA will be to coordinate activities between the regional offices and headquarter's programs and to identify priority areas for concentrated efforts. One such area is the planning for relocation of patients from substandard nursing homes. While the Administration on Aging has been delegated specific responsibilities in this area, its efforts are that of highlighting needs and resources and must be coordinated with those activities of the health and financing agencies.

During coming months, special attention will be given to the data needs and the research and development required to support planning for a long-term care benefit under national health insurance. Since long-term care involves not only the elderly but the impaired of all ages, special attention will have to be given to the long-term care needs of children and disabled adults. ONHA will continue to coordinate the research efforts in long-term care in the various health programs and with the other Department programs concerned with the elderly and the disabled. These efforts should lead to the more effective utilization of research findings and identification of gaps in research efforts.

A positive long-term care provider certification program will be continued, including establishing or modifying procedures at the State and regional levels in order to meet new requirements such as issuance of time-limited agreements, termination of agreements, funds cutoff, waiver approvals, and public disclosure.

Training will be conducted and coordinated to strengthen survey and certification functions at regional and State levels with special attention to the Life Safety Code.

The quality of long-term care will be upgraded through technical assistance to State agencies and providers and short-term training of provider personnel.

Several of the data programs developed or being developed within the Department contain certain information about long-term care facilities and needs. This includes the National Center for Health Statistics' Nursing Home Survey, the Bureau of Health Insurance's Health Insurance Data, the Medical Services Administration's Management Data and the Experimental Health Delivery System's Data. Attention will be given to consolidating these data and to helping in the development of a more consistent data base at both headquarters and regional levels.

ITEM 18. OFFICE OF ECONOMC OPPORTUNITY

MARCH 5, 1974.

DEAR MR. CHAIRMAN: We are pleased to submit at your request, a summary of the activities and programs of the Office of Economic Opportunity during 1973 on behalf of the elderly poor.

During a year in which the appropriations of OEO have been reduced, it is noteworthy that funds for older persons programs has remained nearly constant and the percentage of agency funds for elderly programs has actually increased over 1972 and 1971.

Our report includes narrative and illustrative accounts of the respective types of programs the 905 community action agencies administer. Of particular importance to your committee are the documents and tables displaying the increased earmarked funding of the Senior Opportunities and Services Program and the increased number of beneficiaries and services delivered.

If I can be of any other assistance, please do not hesitate to call on me.

Sincerely,

Acting Associate D LEIGHTON SATTE

[Enclosures]

OFFICE OF ECONOMIC OPPORTUNITY PROGRAMS FOR ELDERLY POOR—1973

The Office of Economic Opportunity survey of Community Action Agencies in 1973 was not only to gather and classify specific program characteristics of the nearly 200 SOS programs now in operation nationwide, but to collect and analyze information, to the extent possible, concerning the wide range of CAA multi-generational activities and programs also reaching and serving the elderly poor.

In addition to the 900,000 elderly poor benefiting from SOS programs, results of the OEO national survey indicate that over 1,000,000 elderly poor are reached and served by Community Action Agency's 12 multi-generational programs. Survey data contained responses from 700 Community Action Agencies, or approximately 80 percent of all Community Action Agencies currently in operation. Relevant findings of the survey are summarized below under appropriate headings.

PRIORITIES

Of 700 Community Action Agencies responding to OEO questionnaires, virtually 100 percent listed the elderly poor as a recognized priority. Half of the CAAs (355) reported the elderly poor as one of a series of ranked priorities; the other half included the elderly poor as a priority under such categorical needs as housing, health, and transportation.

CAA PROGRAM SERVICES FOR ELDERLY POOR 55 AND OVER

Of all Community Action Agencies surveyed, only 15 percent reported that they conduct no specific, identifiable services or programs for the elderly poor. In addition to the 198 Community Action Agencies that reported operating SOS programs, *453 other CAA's reported special Senior Citizens programs.*

On a percentage basis, Community Action Agencies reported that 13.7 percent of their general program funds, *exclusive of SOS programs,* benefit the elderly poor aged 55 and over. Urban CAA's reported 11.6 percent; rural CAA's, 17.7 percent. In individual OEO program categories, CAA services to the elderly poor ranged from 25.4 percent for Emergency Food and Medical Services to 5.2 percent for general recreation programs.

Serving age 55 and above

Program title:	Percent
1. Legal services	12.7
2. Comprehensive health	14.4
3. Emergency food and medical services	25.4
4. Adult education	9.7
5. Housing services	18.1
6. Housing development corporations	15.3
7. Community health	18.7
8. Consumer action	18.1
9. Cooperatives	13.5
10. Recreation	5.2
11. General social services	11.7
12. Other	14.8
Average of total	13.7
CAA urban funds	11.6
CAA rural funds	17.7

SOS PROGRAMMATIC DATA FOR FY 1973

SOS was created and authorized by the 1967 Amendments to the Economic Opportunity Act. It was designed to identify and meet the special economic, health, employment, welfare, and other needs of the elderly poor above the age of 60 in projects which serve and employ older persons as the exclusive or predominant participant or employee group. The projects deal with those problems of the elderly poor that cannot be met by more general programs of OEO designed to serve multigenerational groups.

Such projects develop and provide new employment, volunteer services, and referral; stimulate and create additional services and programs to remedy gaps and deficiencies in existing programs; and attempts to modify existing eligibility requirements and program structures to facilitate the greater use of, and participation in, public services by the elderly poor. The projects provide maximum opportunity for the elderly poor to develop, direct and administer such programs, while utilizing existing services and other programs to the maximum extent feasible.

Since the elderly poor vary as much in their needs, capabilities, and aspirations as other age groups in the poverty population, the strategy behind most SOS programming efforts is to devise and to offer a multiplicity of integrated services to the elderly poor in central and convenient locations. It should be mentioned that other Federal agencies and departments, as well as State and local institutions, cooperate with the Office of Economic Opportunity in providing such services through centralized delivery systems, wherever possible.

Considering the advanced age of most participants in SOS programs (71 years of age), the major objective in SOS programming is to provide physical and psychological supporting services to the elderly poor to enable them to remain, and to function, in their own homes—thus preventing, or delaying, the unwelcome and costly alternatives involved for the elderly when they must enter nursing homes and other such institutions.

NATIONAL SURVEY OF OEO PROGRAMS FOR ELDERLY POOR

During 1973, National Headquarters office, Older Persons Programs, Office of Economic Opportunity for the third year undertook a national survey of activities and programs for the elderly poor conducted by the OEO Community Action Agencies (CAA's). The survey was completed during November 1973, and has yielded comprehensive data for further analysis regarding the two major OEO

program categories for the elderly poor that will be incorporated into a 1973 DIRECTORY OF SOS PROGRAMS:

1. Senior Opportunities Services programs operated by Community Action Agencies funded with Section 222(a)(7) earmarked monies.
2. Multi-generational programs for the elderly poor, operated by Community Action Agencies funded with Section 221 local initiative funds.

Major Categories of SOS Services

With approximately 1500 individual SOS Senior Centers in operation during 1973, or an average of seven separate centers for each SOS project in operation, the following information based on the OEO FY 1971, 1972, and 1973 national surveys indicates the number of SOS programs providing specific major categories of services and the institutional changes effected by SOS.

Type of service	Number of SOS programs offering service		
	1971	1972	1973
1. Civic influence and action	159	153	173
2. Outreach and referral	213	212	248
3. Home health-aide services	78	63	69
4. Other health services	77	98	127
5. Homemaker services	83	75	89
6. Housing assistance	130	142	180
7. Home repair services	57	68	86
8. Handyman services	48	52	61
9. Transportation assistance	197	205	261
10. Legal services	71	85	115
11. Employment training and referral	123	120	133
12. Consumer education	118	132	174
13. Other education	112	117	139
14. Credit unions—buying clubs	50	52	46
15. Home-delivered meals	60	82	126
16. Congregate meals	59	86	147
17. Other meals programs	24	33	45
18. Recreation and/or social programs	175	176	214
19. Handicrafts	180	180	218
20. Friendly visiting services	148	153	186
21. Telephone reassurance program	116	112	132
22. Other	58	91	96

The funding level for SOS programs has risen from $8 million in 1972 to $10.7 million in 1973 of which $258,000 was utilized to benefit Indian and Migrant elderly poor. During 1973 there were 198 SOS projects funded resulting in 1500 Senior Centers. (Tables II & III.)

Results of the 1973 national survey indicate that approximately $22.6 million in Federal funds was available to SOS projects including prior year funds, of which 50 percent represented OEO earmarked SOS appropriations; 24 percent, local initiative funds; 16 percent Title III Administration on Aging funds; and 30 percent from other Federal. Somewhat more than half of the OEO-SOS programs are classified as rural, although rural SOS program dollars account for somewhat less than half of the total program dollars. (Table IV.)

Local non-Federal support for SOS programs, which is approximately $5.1 million, or 22 percent of the total $22.6 million, in Federal funds available to SOS projects.

Voluntary Services

Many of the 198 SOS projects in 1973 depended significantly upon local volunteers to provide services to the elderly poor. Survey results indicate that a total of 69,215 Americans in local communities volunteered 2,938,259 hours during 1973 to the elderly poor. The amount of aggregate volunteer time amounted to 1202 full-time employees, or an average equivalent of full-time persons for each SOS project.

SOS Program Beneficiaries

In 1973, the SOS Program reached and served a total of 990,302 elderly poor—an average, approximately, of 5,000 persons in each SOS project. The SOS projects provided 7,877,360 individual services, including repetitive services, for the year. Based on a study in 1970, the median age of SOS participants is 71 years.

SOS Program Costs

The average cost annually for each individual served by the SOS Program in 1973 was $23 in Federal funds and $5 in non-Federal support for the programs. This annual cost is to be compared to a cost of $5,000 or more annually for institutional care for the elderly, notwithstanding costs in human dignity and happiness. The average cost for individual services provided by SOS projects amounted in 1973 to $2.86 in Federal funds and $.66 in non-Federal funds.

SENIOR OPPORTUNITIES AND SERVICES PROGRAM, OFFICE OF OPERATIONS

During this past Fiscal Year (FY 1973) the Office of Economic Opportunity funded 198 SOS projects in 45 states and Puerto Rico. The funding level was in the amount of $10.7 million and compared with $8 million in FY 72.

Since the first funding of 60 SOS projects in June 1978, in the amount of $2.5 million, the programs have increased more than three-fold and the funding more than 400 percent. Furthermore, the programs have been among the most successful of all OEO programs, and during their seven years of existence have generated over the years the average of $30 in local resource funds for every $100 of federal funding.

The nearly 200 SOS projects operated by CAA's or delegate agencies of CAA's served 990,000 low-income elderly in FY 1973 and provided 7,900,000 individual services to the program participants.

Among the 20 different types of services and activities provided by the SOS projects, the list below provides some of the most significant and representative program elements.

1. 1,500 Senior Centers
2. 69 Home Health Aid Services
3. 89 Homemaker Services
4. 261 Transportation Assistance Services
5. 126 Home Delivered Meals
6. 147 Congregate Meal Services
7. 45 Other Types of Meal Services (primarily Food Stamp Assistance)

The 69,000 volunteers contributed 2,938,000 hours of their time to expand the efforts and make more available the services the SOS projects provide.

Much of the change in language and emphasis contained in the 1973 Amendments to the Older Americans Act is the direct result of the success of the OEO-SOS program in providing new methods of delivering services to the elderly poor.

Title VII of the 1973 Older American Comprehensive Services Amendments mandates the Administration on Aging (AOA) to give priority in the feeding (meals) program to the elderly poor. Likewise, in Title III of the Act, as Amended, the elderly poor and concentrations (high impact areas) are to be given priority by the States in their "Comprehensive Service Areas and Plans."

What about the future of the SOS Program? No one knows for sure at this time what will happen to them. Some projects have received promises and assurances that local funding will be provided to operate them at reduced levels. Few, if any, have any sanguine prospects of receiving from any single or several sources, funds sufficient to continue operation at the level sustained during FY 73.

This agency is looking into several ways through which the SOS Program can be continued, but it must be obvious that most will not continue beyond June 30, 1974, unless they receive general Revenue Sharing funds or are incorporated in the Administration on Aging's State agencies' plans for the operation of programs authorized by Titles III and VII of the Older Americans Comprehensive Services Amendments of 1973.

HIGHLIGHTS OF SELECTED SOS PROJECTS

Eastern Oregon Community Development Council, La Grande, Oreg.

Negotiated and successfully acquired Revenue Sharing funds for transportation services in a three-county area. At the request of OEO State and Regional offices, received $60,000 of OEO/EFMS funds to hire Senior Services Developers to serve three administrative districts.

Economic and Social Opportunities, Inc., San Jose, Calif.

The Senior Opportunities and Development Program has converted to a nonprofit corporation. Has served as a catalyst for training seminars specially designed and conducted (under Region IX contract) by the National Council on Aging, conducted surveys on the use of Revenue Sharing funds for SOS in Region IX. Three of their centers: Gilroy, Morgan Hill and San Martin serve Filipino-Americans. The staff is multi-ethnic. The program has provided 25,335 individual services to 3,861 persons including 12,000 health services.

Goldenrod Hills Community Action Council SOS, Walthill, Nebr.

Serves a five-county area. Conducts a retail outlet store for Senior Citizens' sale items in South Sioux City, Nebraska. All proceeds are returned to the Senior Citizens with a small percentage going into the continuing operation.

South Eastern Idaho Community Action Agency, Pocatello, Idaho

The State Department of Social and Rehabilitation Services provides, a full-time professional to develop services for senior citizens. Bannock County Memorial Hospital sends older mental patients to attend some of the programs at the center to aid the patient in his re-socialization process before being released. Nursing homes in the area are invited to send their patients to a regular Thursday luncheon for a community get-together.

TABLE I.—NATIONAL SUMMARY SENIOR OPPORTUNITIES AND SERVICES PROGRAM (SOS) FUNDING DATA

Source	Federal share	Nonfederal share	Total program funding
OEO–SOS sec. 222	[1] $11,219,435	$2,531,634	$13,751,069
OEO–Local initiative, sec. 221	[1] 2,725,601	771,227	3,496,828
Administration on aging	1,845,913	670,237	2,516,150
Other	6,849,235	1,206,719	8,055,954
Total	[1] 22,640,184	5,179,817	27,825,001

[1] Includes fiscal year 1972 SOS ($964,000) and L.I. ($2,037,000) funds expended during fiscal year 1973.

SOS PROGRAM STAFF

Age category	Managerial and professional	Non-professional (including clerical)
Under 50	263	486
50 to 54	54	184
55 to 59	55	375
60 and over	114	1,031
Total	486	2,076

Volunteer services

Number different individuals contributing unpaid time per year	69,215
Total number hours of volunteer time contributed per year	2,938,259
Number VISTA and/or RSVP volunteers serving the program	117

Program participants or beneficiaries

Number different individuals reached or served per year	990,302
Total number individual services provided per year	7,877,360

TABLE III.—OFFICE OF EMERGENCY OPPORTUNITY PROGRAMING FOR THE AGED

	Fiscal year—						
	1967	1968	1969	1970	1971	1972	1973
Total, all programs	[1] 44.8	[1] 48.9	[1] 61.8	131.1	131.8	119.9	
Job Corps and work and training programs	7.7	8.6	10.5	34.0	27.6	27.7	
JOBS	[2]	[2]	[2]	1.0	[4]	[3]	
PSC	[2]	[2]	[2]	1.6	3.3	3.2	
Mainstream	[2]	[2]	8.0	25.8	19.6	19.6	
CEP	[2]	[2]	[2]	5.6	4.7	4.9	
Office of Economic Opportunity	37.1	40.3	51.3	97.1	104.2	92.2	90.1
Program development and demonstration projects	[2]	[2]	1.3	1.3	1.6	1.7	1.5
Housing	[4]	[4]	[4]	.8	.9	.4	.3
Community development	[4]	[4]	[4]	.2	.1	.3	.3
Consumer	[4]	[4]	[4]	.1	.1	.1	.1
Communications	[4]	[4]	[4]	[2]	.1	.3	.2
Rural	[4]	[4]	[4]	.2	.4	.6	.5
Community action operations	21.0	27.1	30.6	56.2	55.8	53.6	59.3
Local initiative	21.0	24.6	24.2	49.4	47.8	45.6	48.6
Senior opportunities and services		2.5	6.4	6.8	8.0	8.0	10.7
Health and nutrition	11.6	9.8	12.6	25.9	30.5	21.7	16.6
Emergency food and medical	1.0	3.0	7.4	11.0	10.6	[2]	[2]
Comprehensive health services	10.6	6.8	5.2	14.1	18.8	21.7	16.6
Alcoholic counseling	[2]	[2]	[4]	.8	1.1	[2]	[2]
Special India programs	[3]	[3]	[3]	4.6	5.4	4.8	5.2
Special migrant programs	[3]	[3]	[3]	2.5	2.8	2.7	2.9
Legal service	1.9	2.9	3.2	3.3	3.7	3.7	4.6
VISTA	2.6	3.0	3.6	3.4	4.4	4.0	

[1] Do not include all EOA programs. See note below.
[2] Incomplete.
[3] Indicates that the project was not then in existence.
[4] Not available.
[5] Unknown.

Note: Such programs as foster grandparents, rural loans, etc., are not included for any year, although previous reports did include them. The reason for not including them this time is that either they are no longer part of EOA or have no funds requested for them, and thus a parallel base of calculation would be difficult to develop. Early migrants and Indians not broken out separately. Beyond 1969, the data vary considerably in consistency.
programs

Informational services provided

Directory of community services	156
Periodic newsletter	131

Services or activities provided older persons by SOS program

Senior centers	1499
Civic influence and ACTION	173
Outreach and referral	248
Home health aid service	69
Other health services	127
Homemaker services	89
Housing assistance	180
Home repair services	86
Handyman services	61
Transportation assistance	261
Legal services	115
Employment training or job finding	133
Consumer education	174
Other education	139
Credit unions or buying clubs	46
Feeding programs	204
Home delivered meals	126
Congregate meals	147
Other	45
Recreation and/or social	214
Handicrafts	218
Friendly visiting service	186
Telephone reassurance	132
C[illegible]	96

TABLE II.—OEO OLDER PERSONS PROGRAMS, NATIONAL SUMMARY—SOS FUNDING, FISCAL YEAR 1973 AND 1974 AND LOCAL INITIATIVE (L.I., 221)

SENIOR OPPORTUNITIES AND SERVICES (SOS) PROGRAMS REQUIRING FUNDING IN FISCAL YEAR 1974

Region	Fiscal year 1973					January to June 1974		
	Number of programs	SOS (222)	L.I. (221)	Non-Federal share	Total program	Number of programs	SOS (222)	Total fiscal year 1974
I. Boston	6	217,000	27,000	61,000	305,000	6	87,250	93,914
II. New York	10	3,745,000	229,705	860,339	4,835,044	7	449,053	449,003
III. Philadelphia	17	289,615	149,894	110,115	549,624	13	106,666	106,600
IV. Atlanta	32	1,116,529	101,672	280,109	1,498,310	34	648,132	609,871
V. Chicago	32	1,338,085	----------	334,520	1,672,605	31	547,239	547,239
VI. Dallas	16	628,622	----------	157,154	785,776	16	212,457	219,427
VII. Kansas City	18	589,500	----------	141,375	730,875	19	206,200	212,000
VIII. Denver	15	489,373	----------	128,695	618,068	11	140,000	140,097
IX. San Francisco	24	985,180	128,000	227,752	1,390,932	25	475,297	503,749
	(3)	----------	[1] (282,946)	[1] (56,589)	[1] (339,535)	----------	118,400	118,400
X. Seattle	21	595,236	----------	149,558	747,794	12	118,400	
Total	191	9,997,140	636,271	2,500,617	13,134,028	174	2,990,027	3,081,210
Indian programs [2]	5	188,000	51,785	2,120	241,905	----------	----------	----------
Migrant programs [2]	2	70,000	----------	----------	70,000	----------	----------	----------
Total	7	258,000	51,785	2,120	311,905	----------	----------	----------
Grand total [3]	198	10,255,140	688,056	2,502,737	13,445,933	----------	----------	----------
	(3)	----------	[1] (282,946)	[1] (56,589)	[1] (339,535)	----------	----------	----------

[1] Program account 05 general community funds were used.
[2] Programs transferred to HEW and DOL respectively.
[3] Excludes research and development.

Note: See app. A for regional/state fundings.

TABLE IV.—COMPARATIVE FIGURES FOR FISCAL YEAR 1972 AND 1973—NATIONAL SURVEY OF SOS PROGRAMS

[Dollar amounts in millions

	Federal share				Non-Federal share				Total program funding			
	Fiscal year—		Change over 1972		Fiscal year—		Change over 1972		Fiscal year—		Change over 1972	
	1972	1973	Amount	Percent	1972	1973	Amount	Percent	1972	1973	Amount	Percent
CEO:-SOS:												
Sec. 222(a)(7)	$7.2	$11.2	+$4.0	+$55.5	$2.2	$2.5	+$0.3	+$13.6	$9.4	$13.8	+$4.4	+$46.8
Local initiative, sec. 221	1.4	2.7	+1.3	+92.8	.4	.8	+.4	+100.0	1.8	3.5	+1.7	+94.4
Total OEO-SOS[1]	8.6	13.9	+5.3	+61.6	2.6	3.3	+.7	+26.9	11.2	17.3	+6.1	+54.4
Administration on Aging	.5	1.8	+1.3	+260.0	.3	.7	+.4	+133.3	.8	2.5	+1.7	+215.5
Other: Includes Operation Mainstream, OEO/EFMS	2.0	6.8	+4.8	+240.0	.6	1.2	+.6	+100.0	2.6	8.1	+5.5	+211.5
Total[1]	11.1	22.6	+11.5	+103.6	3.6	5.2	+16.	+44.4	14.6	27.8	+13.2	+90.4
Number of different individuals (millions)	.7	1.0	+.3	+42.8								
Unit cost:												
Line 3	$12.30	$13.90	+$1.60									
Line 6	$16.00	$22.60	+$6.60									
Total individual services (millions)	5.8	7.9	+2.1	+36.2								
Unit cost:												
Line 3	$1.48	$1.76	+$0.28									
Line 6	$1.91	$2.86	+$0.95									

[1] OEO percent of total Federal share: 1972, 77.4; 1973, 61.5.

OEO EMERGENCY FOOD PROGRAMS FOR THE ELDERLY

Emergency Food and Medical Services program (EFMS) Section 222(a)(5) of the Economic Opportunity Act of 1964, as amended, is to counteract conditions of starvation and malnutrition among the poor by making grants to CAAs, to State and Local, public or private nonprofit organizations or agencies and to Indian tribal councils:

1. By supplementing such other assistance as may be extended under provisions of other Federal programs such as Food and Nutrition Services, Department of Agriculture; DHEW/AOA Title VII Nutrition Programs for the Elderly, Administration on Aging, Department of Health, Education, and Welfare; and the Manpower Administration, U.S. Department of Labor.

2. By extending and broadening other Federal programs to serve economically disadvantaged individuals where such services are not now provided and without regard to the requirements of such laws for local or State administration or financial participation.

OEO/EFMS funds can be used to initiate support and improve feed programs. Funds can be used for planning and establishing a feeding program, if it is clear that OEO/EFMS funds are available only as seed money or start up costs. The major emphasis has been to facilitate necessary changes to improve or to achieve full utilization of existing programs and to create opportunities for community action and institutional change.

Over $6.9 million of the Fiscal Year 72–73 EFMS appropriations were used to support Regional, Indian and Migrant projects, initiate, expand or continue elderly feeding programs. The EFMS funding guidance directed that DHEW/AOA Title VII guidelines were to be used anticipating that operating programs would receive Title VII funding when AOA appropriations occurred.

Each Region had varying degrees of success in generating DHEW/AOA Title VII monies. Approximately 32 community action agencies in Region IX, San Francisco, received $1.1 million in seed money. Of this, sixteen CAAs used $660,000 for planning and establishing a feeding program for the elderly which served as a catalyst in generating 3.5 times or $2,335,148 DHEW/AOA Title VII money for continuing support of local communities with identified needs for nutrition services for the elderly.

OEO RESEARCH AND DEVELOPMENT PROGRAMS FOR THE ELDERLY

Upper Cumberland (Tennessee) Nutrition Program

A nutrition program for older persons in the Upper Cumberland area of Tennessee has been initiated through the efforts of an OEO Rural Regional Coordination Demonstration project. The project is designed to produce data and test methods for obtaining resources from local, state, Federal and/or private groups to respond to problems of poverty.

To fund the nutrition program, the OEO demonstration project by coordination with three Community Action Agencies and other agencies in a 14-county area, were successful in obtaining a Tennessee Commission on Aging grant of $229,000 and $14,500 in matching funds and $30,000 in-kind services from local resources.

The nutrition program will be carried out at 11 sites, and will feed 485 persons. At present 7 sites, feeding 328, are operative. Eighty-five percent of participants are below the poverty level. The Upper Cumberland Human Resource Agency operates the feeding program and the ancillary services are provided by the CAAs serving the Upper Cumberland Development District.

Caney Fork CAA provides buses for the two feeding sites in its area, using its OEO-funded transportation system. Cordell Hull CAA also provides transportation, and in addition has renovated a feeding site, assists in its operation, and furnishes outreach services to recipients. LBJ&C CAA provides sites and outreach services.

Rural Housing Repair Projects

This program has been in existence since 1969. It is administered by the Eastern Kentucky Housing Development Corporation, a delegate agency of the Community Action Council in eastern Kentucky's Leslie, Knott, Letcher, and Perry Counties. The program trains the elderly poor as construction workers to repair homes owned by other elderly poor, including disabled and blind recipients of public assistance.

Approximately 2,279 homes have been repaired since the program was first started four years ago. Approximately 1,000 elderly poor have participated in the program, most of whom were 65 years of age or older.

The home repair project operated in these four counties is a jointly-funded effort which utilizes DOL Mainstream enrollees, OEO funds for administrative support, and HEW grants to buy materials needed for home repairs to homes of welfare families. When families need more repair money than the HEW grants can provide, Farmers Home Administration provides additional funds through its Section 504 loan program.

Transportation for the Elderly

The West Virginia Department of Welfare received an OEO grant in the amount of $4,039,500 Section 221 funds under the Economic Opportunity Act. No more than $240,170 of the funds to be used to prepare a comprehensive Development and Administrative Plan for Transportation Remuneration Incentive Program (T.R.I.P.).

The plan is to address itself to the transportation problems of the low-income elderly and the handicapped people living in a rural and mountainous State, with declining bus service to meet their needs to reach health and social services. The plan is to include (1) direct subsidy of the cost of transportation for the low-income elderly and handicapped; (2) provide funds and technical assistance to develop or improve systems in those areas where no transportation system or inadequate systems exit; (3) prepare maps outlining priority origin-destination patterns; identify primary medical and social service centers to be reached; (4) prepare an inventory of all existing transportation systems and the possibility of improvement and availability of public and private financial resources; (5) develop methods to test hypotheses and research methodology; (6) develop mechanisms and standards to evaluate the program as it affects the needs of the elderly poor.

Release of additional funds is contingent upon OEO approval of the planning and research effort and the grantee's success in securing non-OEO funding commitments sufficient to sustain the program for a four-year demonstration period.

Details of the plan dated November 5, 1973, reviewed as they were being formulated, and in their final form, by an interagency committee composed of representatives from all Federal agencies concerned with TRIP, as follows:

Office of Economic Opportunity
Appalachian Regional Commission
Department of Transportation (Urban Mass & Transit Administration, Federal Highway Administration)
Administration on Aging, HEW

OEO Legal Services for the Elderly Poor

The legal services program now provides about $790,000 for earmarked activities for the elderly, including:

1. $542,000 (through June 30, 1974) for the National Senior Citizens Law Center (Los Angeles, Calif., and Washington, D.C.), which provides legal research and other helpful services for legal services attorneys representing the elderly.
2. $87,000 (through November 30, 1974) for the Council of Elders' (Roxbury, Mass.) lay advocates demonstration program.
3. $160,000 (through June 30, 1974) for the Presbyterian Senior Citizens Center in New York City, which engages in litigation in legal problems affecting the aged.

APPENDIX A

OEO OLDER PERSONS PROGRAMS—SENIOR OPPORTUNITIES AND SERVICES (SOS) AND LOCAL INITIATIVE (L.I., 221) (222) PROGRAMS REQUIRING FUNDING IN FISCAL YEAR[3] 74

State	Fiscal year 1973					January to June 1974		
	Number of programs	Senior opportunities and services (222)	Local initiative (221)	Non-Federal share	Total program	Number of programs	Senior opportunities and services (222)	Total Fiscal year 1974
REGION I—BOSTON								
Connecticut						0		
Maine						0		
Massachusetts	5	178,000	27,000	51,250	265,250	5	77,500	84,164
New Hampshire						0		
Rhode Island						0		
Vermont	1	39,000		9,750	48,750	1	9,750	9,750
Total	6	217,000	27,000	61,000	305,000	6	87,250	93,914
Total sec. 222 SOS allocations		217,000						
Total number of SOS programs	6							
REGION II—NEW YORK								
New Jersey	3	287,629		71,907	359,536	3	118,247	118,247
New York	5	569,471	115,730	37,964	723,435	4	295,752	295,752
Puerto Rico	2	2,887,900	113,975	750,468	3,752,343	1	35,004	35,004
Virgin Islands						0		
Total	10	3,745,000	229,705	860,339	4,835,044	8	449,003	449,003
Total sec. 222 SOS allocations		3,745,000						
Total number of SOS programs		10						
REGION III—PHILADELPHIA								
Delaware	1		12,003	3,001	15,004	0		
Maryland	2	31,000	46,704	19,426	97,130	1	15,500	15,500
Pennsylvania	7	145,704	17	36,668	182,389	7	49,600	49,600
Virginia	2	32,919		8,230	41,149	2	11,000	11,000
West Virginia	5	79,992	91,170	42,790	213,952	3	30,500	30,500
Total	17	289,615	149,894	110,115	549,624	13	106,600	106,600
Total sec 222 SOS allocations		290,000						
Total number of SOS programs		17						
REGION IV—ATLANTA								
Alabama	6	414,327	61,648	116,248	592,223	7	270,058	270,058
Florida	3	43,399	5,000	12,099	60,498	3	21,210	21,210
Georgia	6	171,106	3,000	42,751	216,857	6	96,802	123,132
Kentucky	2	55,677	4,159	14,473	74,309	2	25,668	32,001
Mississippi	3	47,506	6,458	5,052	59,016	4	54,100	54,100
North Carolina	7	203,559	7,407	52,837	263,803	7	99,147	99,147
South Carolina	1	103,319		25,079	128,398	1	34,440	34,440
Tennessee	4	77,636	14,000	11,570	103,206	4	46,607	56,783
Total	32	1,116,529	101,672	280,109	1,498,310	34	648,132	690,871
Total sec. 222 SOS allocations		1,117,000						
Total number of SOS programs		32						
REGION V—CHICAGO								
Illinois	4	165,000		41,250	206,250	4	75,080	75,080
Indiana	4	173,583		43,396	216,979	4	76,665	76,665
Michigan	7	271,918		67,978	339,896	6	100,000	100,000
Minnesota	1	50,550		12,625	63,125	1	12,496	12,496
Ohio	8	320,000		80,000	400,000	8	142,500	142,500
Wisconsin	8	357,084		89,271	446,355	8	140,498	140,498
Total	32	1,338,085		334,520	1,672,605	34	347,239	547,239
Total sec. 222 SOS allocations		1,338,000						
Total number of SOS programs		32						

OEO OLDER PERSONS PROGRAMS—SENIOR OPPORTUNITIES AND SERVICES (SOS) AND LOCAL INITIATIVE (L.I. 221) (222) PROGRAMS REQUIRING FUNDING FISICAL YEAR [3] 74—Continued

State	Fiscal year 1973 Number of programs	Senior opportunities and services (222)	Local initiative (221)	Non-Federal share	Total program	January to June 1974 Number of programs	Senior opportunities and services (222)	Total Fiscal year 1974
REGION VI—DALLAS								
Arkansas	4	108,265		27,066	135,331	4	20,816	24,180
Louisiana	4	248,364		62,091	310,455	4	88,427	88,427
New Mexico	1	17,328		4,332	21,660	1	2,888	2,888
Oklahoma	3	95,150		23,787	118,937	3	27,515	7,515
Texas	4	159,515		39,878	199,393	4	72,811	76,817
Total	16	628,622		157,154	785,776	16	212,457	219,427
Total sec. 222 SOS allocations		626,000						
Total number of SOS programs		16						
REGION VII—KANSAS CITY								
Iowa	3	67,100		15,525	82,625	3	25,000	25,000
Kansas	3	129,000		28,250	157,250	4	62,000	68,000
Missouri	6	189,400		46,600	236,000	6	54,000	54,000
Nebraska	6	204,000		51,000	255,000	6	65,000	65,000
Total	18	589,500		141,375	730,875	19	206,000	212,000
Total sec. 222 SOS allocations		590,000						
Total number of SOS programs		12						
REGION VIII—Denver								
Colorado	9	319,528		79,880	399,408	6	81,370	81,370
Montana	2	57,145		14,286	71,431	2	23,477	23,447
North Dakota	1	19,200		4,800	24,000	0		
South Dakota	2	56,500		20,480	76,980	2	22,917	22,197
Utah						0		
Wyoming	1	37,000		9,249	46,249	1	12,333	12,333
Total	15	489,373		128,695	618,068	11	140,097	140,097
Total section 222 SOS allocations		489,000						
Total number of SOS programs		15						
REGION IX—SAN FRANCISCO								
Arizona	2	65,000		16,250	18,250	3	39,250	50,000
California	18	825,180	113,000	234,002	1,712,182	18	394,333	412,083
	(3)		[1] (282,946)	[1] (56,958)	[1] (339,535)			
Guam						0		
Hawaii	3	80,000		20,000	100,000	3	26,666	26,666
Nevada	1	15,000	15,000	7,500	37,500	1	15,000	15,000
Trust Territories						0		
Total	24	985,180	128,000	277,752	1,390,932	25	475,249	503,749
	(3)		[1] (282,946)	[1] (56,589)	[1] (339,535)			
Total sec. 222 SOS allocations		992,000						
Total number of SOS programs		24						
		(3)						
REGION X—SEATTLE								
Alaska	2	78,900		19,726	98,626	0		
Idaho	4	82,136		20,352	102,488	0		
Oregon	7	238,000		59,500	297,500	6	74,969	74,969
Washington	8	199,200		49,800	249,000	6	43,431	43,431
Total	21	598,236		149,558	747,794	12	118,400	118,400
Total sec. 222 SOS allocations		598,000						
Total number of SOS programs		21						

[1] Program accounts 5 general community funds. This is a nonadd item.

ITEM 19. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
HEALTH SERVICES ADMINISTRATION,
January 25, 1974.

DEAR SENATOR CHURCH: In response to your request of December 21, 1973, find enclosed a summary of the Health Services Administration's major activities on aging during 1973 as described by the Bureaus of Community Health Service, Quality Assurance, Indian Health Service, and Federal Health Programs Service. Since these activities are ongoing, the enclosure material also represents the agency's continuing efforts in the area of aging during 1974.

The Bureau of Quality Assurance submitted certain items related to aging to the Office of Nursing Home Affairs for inclusion in their report to you. Therefore, the agency's summary will not include the aforementioned material.

Sincerely yours,

HAROLD O. BUZZELL,
Administrator.

[Enclosures]

INDIAN HEALTH SERVICE

The Indian Health Program serves 488,839 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 upon the 1970 U.S. Census statistics, persons aged 65 and over represented 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 29,330 aged 65 and over and the 63,550 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, 83 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 the 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 488,839 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 Indian and Alaska Native population with improved health status. From 1960 to 1970 Indian and Alaska Native persons aged 65 and over have increased by 39 percent as compared to 22 percent in the total U.S. population for the same period. Indian and Alaska Native persons aged 45 through 64 during this time period increased by 29 percent as compared with 16 percent in the Nation's total population.

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 Indian Health Service staff in the course of day-to-day operations throughout reservations and Indian communities.

Coordinated services of the Indian Health Service 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 of the Indian Health Service trained Indian community health representative and the Alaskan Native community health aide in specially seeking out the elderly and bringing their individual problems to the attention of appropriate health and social resources, providing transportation to Indian Health Service 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 3,812 individuals or more than 13 percent of the Indian service population aged 65 and over. A total of 12,800 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 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 of the food habits and cultural practices of the Indian and Alaska Natives. The elderly are reached within these services to the family with special emphasis given to improving nutritional health. Individual income and the 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 utilization of these resources to improve the overall nutritional status. Nutrition consultation is provided to Department of Agriculture 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 and 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 assisting the Indian people to utilize 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 Indian Health Service.

BUREAU OF QUALITY ASSURANCE

Activities Benefiting the Aged

When Medicare was enacted in 1965, the Secretary of Health, Education, and Welfare 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 national professionally acceptable standards for some providers of services, particularly for long-term care facilities, home health agencies, and independent laboratories. Qualifications required of many types of health care manpower also were inadequate

to ensure a safe level of quality of services. The Division of Medical Care Standards of the Bureau of Quality Assurance, HAS, 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 directly related to program beneficiaries.

A major objective of the Division in its planning, operations, and evaluation, is the improvement of the health status of beneficiaries under both Medicare and Medicaid by ensuring that the types, quality, and quantity of services provided under the programs are appropriate and adequate for patient needs. Since the onset of the programs, the focus of continuing evaluation of the effectiveness of the established regulations, and their revision as necessary, has been to promote the upgrading of individual provider institutions and agencies, to establish adequate and realistic qualifications for health care personnel, to improve State licensure and certification programs, and to stimulate changes in national accreditation programs in line with ongoing changes in the delivery of health care services.

UTILIZATION REVIEW OF MEDICARE SERVICES

The Division has instituted several ongoing programs to promote and maintain the quality of care provided to elderly persons. Of 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 and in the right amounts. The main thrust of utilization review activities, which is now required under both Medicare and Medicaid, is to increase the effectiveness of surveillance of quality and appropriateness of services, particularly in 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 mechanism for evaluating the quality and effectiveness of health services, as an integral component of the utilization review process.

TRAINING IN QUALITY ASSURANCE

The Division's Training Support Program has as its primary objective to coordinate multiple programs of training for personnel involved in the certification process for providers and suppliers under Medicare and Medicaid and in Professional Standards Review Organizations (PSRO's). In addition to the ongoing training of State agency survey personnel since 1970, toward improving the application of specific standards in the certification process, a program of consultant training for physicians on the utilization review process has now trained 60 consultants for the regional offices. As continuing efforts to upgrade institutional utilization review activities are implemented in preparation for PSRO's, the role of the program in providing utilization review training will increase in close liaison with other divisions in BQA that conduct related programs (i.e., peer review, program review).

In addition to utilization review, a series of specialty courses in consultation will be implemented for State agency personnel. The objective of these courses is to improve both the general ability of surveyors to act as consultants to provider institutions to remedy deficiencies identified in the survey, and the consulting skills of specific professional State agency specialists (i.e., physicians, nurses, dietitians, pharmacists, medical record librarians, etc.).

Currently, working closely with other divisions of BQA, an intramural training program is being developed for regional office personnel (BQA, BHI, and MSA) who are involved in the PSRO program. Longer range training needs are still to be identified, but at least two major training needs are apparent: for BQA personnel administering the program, and for physicians and administrators operating individual PSRO's.

QUALIFYING PERSONNEL UNDER MEDICARE

In establishing standards and surveillance techniques for individual professional health care practitioners to participate in the Medicare and Medicaid programs, many problems were experienced relating to their qualifications and to their availability in sufficient numbers for staffing provider institutions. Various

techniques for ensuring quality services while endeavoring to increase numbers of selected categories of health care personnel have undergone study and experimentation, including the utilization of proficiency examinations. The Division has worked closely with other related Federal agency personnel, as well as with representatives of the professional organizations of various disciplines, in establishing necessary professional qualifications for program participation, and in developing the proficiency examinations.

A proficiency examination was developed in 1970 to qualify certain physical therapists to provide services under Medicare and Medicaid, an effort which has, through the conduct of three examinations for 389 applicants, permitted 42 previously unqualified physical therapists to participate in the programs.

The initial proficiency examination for practical nurses was conducted in September 1973 for 2,260 examinees, which permitted 743 additional waiver-licensed practical nurses to serve as charge nurses in provider institutions and agencies. A fourth examination for presently unqualified physical therapists, and a second for practical nurses, will be conducted in the current fiscal year. Proficiency examinations are in the process of development for presently unqualified cytotechnologists and clinical laboratory technologists, also to be conducted in this fiscal year.

END-STAGE RENAL DISEASE PROGRAM

The Medicare end-stage renal disease (ESRD) program, effective July 1, 1973, provides for the first time a Federal program responsible for financing of care for persons with a "particular" diagnosis. Prior to enactment of section 2991 of Public Law 92–603, many kidney disease patients with need for hemodialysis or transplantation did not receive the services because of lack of financial resources. This legislation is intended to cover the cost of these expensive therapies to all eligible patients with a single medical condition, and constitutes an initial experiment in a form of catastrophic illness health insurance.

Careful planning, incorporating all the principles of ESRD care, has been necessary to allocate resources to ensure access, adequate utilization, quality of service, and reasonable program costs. In view of the new issues that stem from the universal coverage of such a complex service, the absence of prior experience, and possible precedents that the regulations may establish, final discussions on Medicare payment and facility qualification policies will require careful study and reevaluation based upon operating experience.

Interim regulations for the program were published in the June 29, 1973, Federal Register. These regulations permit facilities that provided ESRD services prior to June 1, 1973, to be reimbursed under the interim program, and set forth criteria for exceptions to be permitted until final regulations are published, presently anticipated by July 1, 1974.

Guidelines for processing and granting exception requests have been developed by the Bureau of Quality Assurance and the Bureau of Health Insurance, SSA, in consultation with the Comprehensive Health Planning Service. These guidelines reflect proposed direction of the long-range program, and have alerted the health industry against making investments that may not be compatible with the long-range program.

SMALL, ISOLATED, LIMITED-SERVICE HOSPITALS

Many of the Nation's small, isolated, rural hospitals, especially the Medicare "access" hospitals, are currently unable to meet the program's health and safety standards, and are permitted to participate under a special certification only because of the need to have services available for Medicare beneficiaries living in isolated locations. Under a contractual study initiated July 1, 1972, proposed standards designed as being realistic and appropriate for this type of limited-services hospital were developed with an overall objective of improving quality and availability of health care for the elderly in isolated rural areas. The standards have been test-surveyed and the findings reviewed by the advisory board, and it is expected that the study recommendations will be forthcoming within the current fiscal year. Results should include clear definitions of services that can be provided safely and adequately in access hospitals in the Medicare (and Medicaid) programs, recognizing the limitations in range and the patterns of delivery of such services in isolated rural areas, and more appropriate surveillance of such hospitals.

MEDICARE COVERAGE ISSUES

A principal function of the Division's medical staff is to provide consultation to the Social Security Administration on medical problems that arise, many of which are connected with review of the appropriateness of care provided to individual Medicare beneficiaries. Section 1862(a)(1) of the Medicare law prohibits payment for expenses incurred for time or services ". . . which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Decisions on coverage issues regarding services provided under the program as they relate to this statutory requirement are the ongoing responsibility of the Division.

BUREAU OF COMMUNITY HEALTH SERVICES

ACTIVITIES IN AGING

Programs of the Bureau of Community Health Services are designed to ensure optimum health care for the total community. Thus, while the aged are not singled out as a specific segment of the population which warrants principal focus, the betterment of their health and welfare is promoted through various program efforts which affect the health of all age groups. Bureau activities which impact most significantly on aged populations are provided through community and family health centers, migrant health projects, health maintenance organizations and the National Health Service Corps.

COMMUNITY AND FAMILY HEALTH CENTERS

A. Community Health Centers

The Bureau is currently administering approximately 118 community health centers which are providing a range of preventive, therapeutic and rehabilitative ambulatory services to an estimated target population of 4.7 million persons. The centers, which include former OEO projects transferred to DHEW over the past several years, are located in both urban and rural areas scattered throughout 38 States, the District of Columbia, and Puerto Rico.

B. Family Health Centers

In addition, the Bureau of Community Health Services funds 39 family health centers. Built on a prepaid group practice concept, these are designed to provide a prescribed package of ambulatory health care benefits to a specifically enrolled population residing in a defined medical scarcity area. While only a limited number of these are currently delivering services, they have an eventual target enrollment potential of 525,000.

C. Data

While data are not available on all community health centers, recent quarterly reports from 86 centers indicate that 6 percent of the total registrants are age 65 and over. These reports further indicate that this age group represented 8 percent of MD users, and that 10 percent of the high frequency users (three or more MD encounters during the quarter) were in this age range. Thus, this relatively small proportion of registrants utilized a disproportionate amount of the services in these health centers.

We expect, also, that approximately 8 to 10 percent of those served by family health centers will be elderly. Utilization data are not currently available for these centers, but they are expected to start meeting national reporting requirements during fiscal year 1974.

MIGRANT HEALTH PROGRAM

The Migrant Health Program is designed to provide access to health care services for migrant and seasonal farmworkers and their families. As a group, the migrant family represents an underserved segment of the population in terms of most social and health services. The elderly migrant, generally uneducated, often unable to speak English, and living in remote rural areas without access to health services, suffers from an even more intensified lack of services. In addition, the aged 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 travels north from 3 to 7 months of the year looking for work.

Of the approximately 338,000 migrants and seasonal farmworkers who received services in this program in 1973, 3,700 are estimated to be 65 years of age or older. Most of these are women who are traveling with 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 migrants and seasonal farmworkers and their families. Within the often limited availablity of local resources, arrangements will continue to be made by project workers for inpatient hospital care for these persons and for nursing home care, as needed, for the elderly migrant.

HEALTH MAINTENANCE ORGANIZATIONS

The Health Maintenance Organization (HMO) Program was created within DHEW as a result of the President's 1971 health message in which he encouraged their development as an alternative to the traditional fee-for-service delivery system. With the recent passage of HMO legislation, the Department is actively engaged in facilitating further growth and expansion of this program. HMO's provide, or otherwise assure the delivery of, an agreed upon set of comprehensive health maintenance and treatment services for a voluntarily enrolled group of persons on a prepaid capitation basis.

Under H.R. 1 (Public Law 92-603, section 226) "Medicare is authorized 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." Based on this regulation, the Department is currently completing work on the drafting of interim regulations governing the participation of HMO's in Medicare. Nearly 200 organizations have expressed an interest in participation. In addition, the requirements of section 1833(a)(1) governing the payment of Group Practice Prepayment Plans (which cover only part B services) will be conformed to the section 1876 requirements. There are currently 34 direct-dealing Group Practice Prepayment Plans and 40 carrier-dealing GPPP's.

While HMO services are available to all persons in a given geographic area who enroll in the HMO, the emphasis on accessibility, prevention, quality of care, efficiency, and cost consciousness makes this health care option particularly valuable to the aged in view of their higher-than-average utilization of services.

NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps is designed to improve the delivery of health services to persons residing in areas with critical manpower shortages. The desire is to place self-sufficient teams of health professionals which will establish successful practices in shortage areas and continue to provide services in these areas. By the end of fiscal year 1973 there were a total of 335 health professionals assigned to 183 shortage area communities.

As is the case with other BCHS activities, services provided through Corps projects are not specifically designated for the elderly although members of this population group who reside in the funded health manpower shortage areas are eligible for services. Most of the projects are located in rural areas—places where there are heavy concentrations of elderly persons.

As of December 31, 1973 a total of 81 of the 183 projects are located in communities in which the elderly comprise 10 percent or more of the target population.

MEMORANDUM

DATE: January 16, 1974.
TO: Acting Administrator, Health Services Administration.
FROM: Director, Federal Health Programs Service.
SUBJECT: Reply to request for information for Senate Special Committee on Aging.

FEDERAL HEALTH PROGRAMS SERVICE

The Federal Health Programs Service has no programs which of themselves relates 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 fiscal year 1973, of a total of 31,397 discharges from hospitals of the FHPS, 3,993 were over 65. The average length of stay for

elderly men was 22.4 days and for elderly women was 19.6 days, compared with an average length of stay of 16.3 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.

ROBERT E. STREICHER, M.D.,
Assistant Surgeon General.

ITEM 20. OFFICE OF CONSUMER AFFAIRS

FEBRUARY 1, 1974.

DEAR SENATOR CHURCH: In response to your request of December 21, I am enclosing a report on activities of the Office of Consumer Affairs during 1973 that relate to the aging.

We are pleased to contribute to the annual report prepared by the Special Senate Committee on Aging to summarize developments related to Federal policy and actions affecting older Americans.

Sincerely,

VIRGINIA H. KNAUER,
Director.

[Enclosures]

REPORT OF THE ACTIVITIES OF THE OFFICE OF CONSUMER AFFAIRS DURING 1973 RELATING TO THE AGING

Mrs. Virginia H. Knauer serves as the Special Assistant to the President for Consumer Affairs and as Director, Office of Consumer Affairs. On March 18, 1973, the Office of Consumer Affairs was organizationally streamlined and relocated within the Office of the Secretary, Department of Health, Education, and Welfare, for the sake of economy and efficiency.

The Office of Consumer Affairs assures that the consumer's interest is reflected in Federal policies and programs, cooperates with State agencies and voluntary organizations in advancing the interests of consumers, promotes improved consumer education, recommends legislation of benefit to consumers, encourages productive dialog and interaction between industry, government and the consumer, and provides continuing policy guidance to the Consumer Product Information Coordinating Center. Among its other duties, the Office provides staff support to the Special Assistant to the President for Consumer Affairs.

DOMESTIC COUNCIL COMMITTEE ON AGING

Mrs. Knauer participates in meetings of the Domestic Council Committee on Aging, charged by the President with responsibility for developing, coordinating and presenting to him both short-term and long-range policy issues in this area.

CONSUMER LEGISLATION

The Office of Consumer Affairs has had a significant role in shaping the Administration's consumer legislative program.

Mrs. Knauer often makes her views known to the Congress and Federal administrative agencies regarding issues of concern to the consumer.

Of particular interest to the aging was her testimony on food prices before the Senate Subcommittee on Production and Stabilization in April 1973, and on hearing aid adaptability to new generation telephones before the Senate Subcommittee on Consumer Interests of the Elderly in September.

Mrs. Knauer also participated in the review of the recommendations of the President's Commission on Financial Structure and Regulation, known popularly

as the Hunt Commission. In designing proposed legislation based on these recommendations, she acted as an intermediary between the Administration and the consumer community, including the elderly. This legislation, when enacted, should improve the continuing availability of reasonably priced consumer credit, provide for a fair return on consumer savings, and generally improve the services which financial institutions make available to consumers.

On March 12, 1973, Mrs. Knauer testified before the Federal Trade Commission recommending that the holder-in-due-course doctrine be abolished as it relates to consumer installment credit transactions.

National Voluntary Organizations, Advisory Groups

The Office of Consumer Affairs has continued to maintain close liaison with national associations having special interests in the problems of the elderly, particularly the National Retired Teachers Association (NRTA), American Association of Retired Persons (AARP), the National Council of Senior Citizens (NCSC), and the National Consumer Information Center (NCIC). OCA has encouraged and assisted these groups in developing consumer information and education programs, and in expediting the handling of consumer complaints coming to our attention. For instance, the Office has worked closely with NRTA/AARP's Consumer Committee as to its program planning. The Office has assisted efforts of the NCIC to continue its work with local community programs aimed at helping the low-income consumer, especially the low-income elderly consumer living on fixed income.

The Office of Consumer Affairs has also continually worked to assure that spokesmen for the elderly be included in consultations seeking consumer leader advice on national policy issues. In this connection, OCA made sure that representatives of the elderly participated in special White House consultations regarding the Cost of Living Council's Phase III programs, and the Administration's proposals regarding financial reform.

Also, the interests of the elderly are represented on both the Consumer Advisory Council of the Office of Consumer Affairs and on the National Consumer Energy Advisory Committee.

The OCA Consumer Advisory Council has had a continuing concern for the consumer problems of the elderly. The Council's Chairman, Eunice Howe, continued to serve on the Post-Conference Board of the White House Conference on Aging and was most instrumental in formulating the report regarding the consumer problems of the aging which was published in the *Post-White House Conference on Aging Reports, 1973*. Former Council member Dr. Wilma Donahue also served as Director of the Post-Conference Board. The Council also urged the development of food buying clubs and other approaches to alleviate the critical impact of inflationary food prices on the fixed incomes of the elderly. The Council was pleased that its earlier recommendation to the Food and Drug Administration came to fruition with the FDA announcement during the past year establishing guidelines for voluntary nutritional labeling for foods.

Members of the National Consumer Energy Advisory Committee were selected by OCA at the request of Mr. William Simon, Administrator of the new Federal Energy Office. A key member of the NCEAC is Mr. Bernard E. Nash, executive director of the National Retired Teachers Association and the American Association of Retired Persons.

Industry Relations

The Office of Consumer Affairs during 1973 continued to work with industry to encourage and develop voluntary industry action to aid the consumer, including the aging consumer.

As a result of special efforts to encourage several major consumer industries to establish mechanisms to handle complaints against their particular industries, the National Automobile Dealers Association has established 12 pilot programs (AUTOCAP); the Southern Furniture Manufacturers Association has established a furniture industry consumer action panel (FICAP); and the carpet and rug industry, a panel for that industry (CRICAP).

Also, commitment has been obtained from the Opticians Association of America to develop a two-part consumer complaint-handling program, and the National Association of Insurance Commissioners has adopted a uniform regulation for the cost comparison of life insurance. Efforts have been continued to

encourage the research, development, and use of hearing aid adapter devices for telephones and, as stated earlier, Mrs. Knauer has testified on this matter before the Senate Subcommittee on Consumer Interests. The Office of Consumer Affairs also participated in the Ad Hoc Interagency Committee on Third Party Prepaid Prescription Drug Programs; has urged adoption of nutritional labeling and improved implementation of unit pricing; and encouraged the adoption of uniform retail meat identity standards.

In the year ahead, the Office of Consumer Affairs will make a major effort to obtain retailing chain support for standardization of useful comparative product information ("fact tags") for consumer durables; encourage development of a nationwide network of the AUTOCAP panels; industry-wide participation in the furniture complaint handling mechanism; assist in further development of the Opticians Association complaint handling program; seek to obtain agreement for industry trade association development of a catalog listing industry offices and officials for handling consumer complaints, and to provide proof of advertising claims; and seek industry resolution of problems of hearing aid users arising from incompatibility of new telephones and existing hearing aid devices.

State-Local Programs

The Office of Consumer Affairs continued to maintain liaison with State and local officials in all 50 States, Puerto Rico, Guam, Virgin Islands, and American Samoa, and to work for effective State and local consumer laws and offices, serving as a clearinghouse and providing technical assistance. The special problems of the elderly consumer are brought to the attention of State and local officials.

In 1972, the Office of Consumer Affairs reported the publication of two new consumer booklets: *State Consumer Action—'71*, a comprehensive listing of State and local governmental consumer action during 1971; and a directory of currently existing city, county and State consumer offices. New editions of both booklets were published in 1973. *State Consumer Action—'72* provides summaries of laws and administrative programs of State, county and city governments especially to focus attention on innovative and effective approaches to consumer problems, including those of the elderly. A more comprehensive and updated directory, entitled *Directory to State, County, and City Government Consumer Offices*, was compiled to assist in interoffice communications and to aid consumers in directing problems to the appropriate office. The directory was made available to the general public through the Government Printing Office. (Copies of both publications are attached.*)

New editions of these booklets will be published in 1974.

The Office of Consumer Affairs, in its advisory capacity to the Federal Executive Boards, proposed that during fiscal year 1974 the FEB's focus attention on two or three major consumer areas, and suggested the following programs:

1. Establish FEB-Community Consumer Councils to provide regular contact between Federal agencies and representatives of key community groups, including senior citizens organizations; to expedite the flow of information to the public; and to provide guidance to interested parties who wish to comment on Federal agency proposals.
2. Implement programs to assist the elderly consumer.
3. Develop an operational plan to establish emergency consumer aid offices to assist consumers in the event of natural disasters.

The FEB in five cities have convened first meetings of a Community Consumer Council, whose membership includes representatives designated by the National Retired Teachers Association/American Association of Retired People and the National Council of Senior Citizens. These cities are: Chicago, Cleveland, Atlanta, Dallas and Portland, Oregon. Councils are expected to be organized in seven additional cities.

The FEB Consumer Affairs Conference called by OCA for August 15–16, 1973, was addressed by Dr. Arthur Flemming, Commissioner, Administration on Aging. Representatives from the Administration on Aging and the Social Security Administration participated in the workshop on The Elderly Consumer which followed, to answer questions and to offer suggestions relevant to the development of programs to assist the elderly. The FEB's in 17 cities are planning a variety

*Retained in committee files.

of programs to aid the elderly. These cities are: Albuquerque; Atlanta; Baltimore; Boston; Chicago; Cincinnati; Cleveland; Detroit; Honolulu; Kansas City; Los Angeles; Miami; New York; Pittsburgh; Portland, Oregon; San Francisco, and the Twin Cities. Some examples of their progress follow:

BALTIMORE

The Baltimore FEB obtained the loan of a mobile van from the local Better Business Bureau for the period October 15–November 16, 1973, which they used to provide information and assistance on consumer problems to senior citizens in Baltimore and five surrounding counties.

In cooperation with the Maryland Commission on Aging, city and county commissions on aging, the American Association of Retired Persons, senior housing centers, community colleges, and the Ecumenical Conference on Aging, 24 meetings were arranged for the van during that period at congregate meeting sites of the elderly, including senior residential centers and feeding stations in the DHEW title VII nutrition program. The van was staffed by volunteer personnel from agencies having direct services reating to the elderly, with four to six representatives participating at each scheduled location.

A total of 10 Federal agencies, five county agencies, three city agencies, two State agencies, and two quasi-Government agencies took part in the project. 1,049 senior citizens were personally contacted. Every individual problem was referred to a responsible agency for action.

The project will be continued as a monthly project, or as requested, for the remainder of fiscal year 1974.

CINCINNATI

The Cincinnati FEB has established a team composed of representatives from the Internal Revenue Service, Veterans Administration, Social Security Administration, U.S. Department of Agriculture, Postal Service, Food and Drug Administration, the Federal Information Center, and the Cincinnati Council on Aging to hold a series of on-site forums to provide information and to answer questions regarding specific programs, services and problems of the elderly. This team has held one successful meeting at a senior citizens center and five more are planned.

DETROIT

The Detroit FEB has arranged a series of thirteen educational programs on concerns of the elderly, ranging from health care and tax matters to mail fraud and burial problems, which will be presented on alternate Tuesdays, beginning January 15, 1974, to the leaders in charge of 39 feeding stations in the DHEW title VII nutrition program in the city of Detroit. In addition, arrangements have been completed with the Wayne County Senior Citizens Commission to present the same programs to the leaders from eleven congregate meeting sites for the elderly in Wayne County, beginning about March 1.

MIAMI

The Miami FEB has arranged for a representative from the Dade County Consumer Office to occupy a desk in the Miami Beach Social Security office, beginning January 23, 1974, to give on-the-spot assistance to the estimated 400–600 elderly consumers who visit that office each day.

If this effort is successful, it will be expanded to include other Social Security offices in the Miami area having a large traffic of elderly persons.

PITTSBURGH

The Pittsburgh FEB has established a liaison with local western Pennsylvania chapters of the American Association of Retired Persons to obtain information on consumer problems of chapter members which the FEB could assist in resolving. A training session for the leaders from 35 AARP chapters and other adult groups will be held on February 15, 1974, at which representatives from Federal and local agencies will discuss the rights of consumers, how to complain, how to make referrals, and where to go for assistance with specific problems.

Suggested project No. 3, Preparation of a Disaster Emergency Plan to Assist Consumers, has been undertaken by the FEB's in 12 cities. These cities are: Balti-

more, Boston, Buffalo, Dallas, Detroit, Los Angeles, Honolulu, Miami, Philadelphia, Newark, San Francisco, and the Twin Cities.

As a result of this planning, the FEB's in two cities have been able to move quickly to assist the consumer when disaster struck.

The Newark FEB sent one of its members to the Plainfield, N.J., disaster assistance office to provide advice and assistance to consumers with such flood-related problems as insurance and contractual work when that area experienced a major flood in September 1973.

Following the Chelsea, Mass., fire in October 1973, the Boston FEB set up a consumer aid service in the Federal Disaster Center to handle consumer complaints; provide legal assistance in such areas as loan transactions, contract clauses, landlord-tenant issues, and to assist victims of the fire in filling out the many forms needed to qualify for the various programs available under the Federal Disaster Assistance Act.

This consumer Disaster Emergency Plan will be of particular benefit to the elderly, who are usually the least able to help themselves when disaster strikes.

OCA is preparing, in cooperation with the Federal Disaster Assistance Administration, a guide to assist government officials at any level of government as well as communities themselves in establishment of Emergency Consumer Aid Centers in the event of a natural disaster. The guide puts special emphasis on the need to make a center meet the special needs of the elderly.

Federal Programs

In response to the request of the President and recommendations on both the White House Conference on Food, Nutrition and Health and the Senate Select Committee on Nutrition and Human Needs, the Office of Consumer Affairs, as Federal coordinator, the Departments of Agriculture and Health, Education and Welfare, the Grocery Manufacturers of America, and the Advertising Council developed a national Nutrition Awareness Campaign to improve public awareness of the importance of nutrition to good health and well-being.

Central to the campaign is the booklet, *Food is More Than Just Something to Eat*, a compendium of the basic nutritional information necessary for intelligent dietary decisions, which was prepared by USDA and OCA. The booklet, which is promoted by the campaign's radio and television commercials and newspaper and magazine advertisements, features sections on the special nutritional needs of various age groups, including the elderly. It is printed in large size type for ease in reading. Copies are available free from Public Documents Center, Pueblo, Colo. 81009.

Other information in the booklet, such as the descriptions of the major nutrients, the explanation of nutritional labeling, and the daily food guide, relate so well to the aged that DHEW's Administration on Aging has purchased 65,000 copies for distribution to State and local agencies for the aged to assure that these organizations and their staffs are aware of the booklet and can recommend it to the individuals they serve.

OCA is assisting the reorganized HEW Office of Nursing Home Affairs both to determine how and where consumer participation in an informal advisory setting could be most effective in achieving ONHA's objectives, and to identify representative consumers to serve in this capacity.

An Approach to Consumer Education for Adults was published by the Office of Consumer Affairs on January 1, 1973. Its purpose is to assist educators establish and conduct consumer education programs for persons beyond the high school level. Its focus is on decision-making in the marketplace, including obtaining and evaluating product information and services, assessing personal values, managing money, and understanding rights and responsibilities. It offers practical suggestions for structuring adult consumer education programs, and describes five case studies where consumer knowledge can protect the individual.

In a short section on "consumers with special needs," the adult guidelines address particular problems of the elderly, especially those who live alone and who must depend on fixed incomes. These problems are: food and nutrition, housing, health care and services, and transportation.

The Pueblo Indian Consumer Education and Advocacy Program (New Mexico) is a demonstration project, now in its second year.

Operated by an all-Indian staff from the All Indian Pueblo Council, this program has trained Indian consumer officers from the 19 Pueblos. These officers,

backed by a small central staff in Albuquerque, work out of individual offices on their Pueblos. They conduct consumer education classes which many elderly Indians actively attend; they make home visits to discuss consumer problems with the Pueblo families; they help resolve consumer complaints; they are impacting on the Pueblo populations and measurably increasing consumer awareness.

Because the consumer officers all speak their native Pueblo language, they are able to talk with the elderly citizens. In fact, the link between the young consumer officers and the elderly Indians has generally been a very beneficial and mutually supportive one, in that the young consumer officers help the elderly with their problems and the elderly, in turn, support the work of the young. In the Pueblo culture support from the elders is essential to the success of any community project.

PUBLICATIONS

In 1973, the Office of Consumer Affairs published *Nursing Home Care*, a booklet in the Consumer Information Series of the Department of Health, Education, and Welfare. Of prime significance to the elderly and their families, this publication describes different kinds of nursing homes, offers criteria for judging homes, discusses charges and availability of help from Medicaid and Medicare. Prepared in cooperation with DHEW's Medical Services Administration (Social and Rehabilitation Service), the booklet has been widely distributed by both agencies as well as being sold by the Government Printing Office. Promotion for the publication has been handled by the Office of Consumer Affairs.

Also published in 1973, *Tooth Care* is another booklet from the DHEW Consumer Information Series, developed in cooperation with National Institute of Dental Research and Division of Dental Health (National Institutes of Health). Designed to cover family dental care in a comprehensive fashion, the booklet features sections of special interest to the elderly: dentures, costs of dental care, and Government programs that help pay costs.

In addition, two publications dealing with food and nutrition, a particular problem area for senior citizens, were published during 1973; one, *The Professional Shopper*, includes, in booklet form, a series of eight articles prepared in 1972 by Mrs. Knauer and widely reprinted in food sections of newspapers across the country. Continued interest in this timely series prompted the booklet version. The second, *Money Saving Meals*, was produced, at OCA's request, by the Department of Agriculture. To date, USDA and OCA have filled almost 260,000 requests for this publication.

Consumer News, Office of Consumer Affairs' twice-a-month newsletter with a circulation of 45,000 is available for $4.00 yearly. Carrying news of Federal programs of concern to consumers, each issue almost invariably contains information of value to older citizens: information about nutrition, hazardous products, drugs, consumer credit, regulations designed to curb fraudulent business practices. Further, special attention is given to reporting Federal programs of special interest to the elderly. Examples from 1973 issues:

—Progress reports on OCA's extended negotiations with Bell Telephone and representatives of the hearing aid industry to solve the problem created by the phone company's installation of new earphones not compatible with existing hearing aid devices. In this endeavor, Mrs. Knauer has invited the cooperation of organizations representing senior citizens as well as groups of people with impaired hearing (March 15; August 1).

—Summary of recommendations, in President Nixon's State of the Union Address, of special concern to older Americans (March 15).

—Summary of DHEW proposals for helping States and communities develop programs for older citizens (Consumer Register, September 15).

—Summary of FAA proposals on special provisions for air travel for the handicapped (Consumer Register, September 15).

—Summary of DHEW announcement of plans to step up its Nutrition Program for the Elderly (Consumer Register, October 1).

—Summary of revisions of DHEW final regulations growing out of title III of the Older Americans Comprehensive Services Amendments of 1973 (Consumer Register, November 15).

(Copies are attached of all issues referred to.*)

*Retained in committee files.

Dear Consumer is a weekly newspaper column by Mrs. Knauer, distributed by OCA to about 7,000 weekly and daily newspapers with circulations under 20,000. In addition to covering topics of general interest to consumers of all ages, these columns frequently focus on topics that are especially appropriate to the lifestyles of older citizens. A few examples: rights of nursing home patients, planning for retirement, Federal food program for senior citizens. (Copies of topics mentioned are attached, as well as others of special interest for older readers.*)

In addition, OCA has continued to distribute publications which were prepared prior to 1973 and which cover a broad range of topics that concern older consumers.

Another nutrition education effort involving OCA, and prepared during 1973, is a series of ten television programs produced by DHEW. Cosponsored by OCA and the Food and Drug Administration, this series consists of panel discussions among outstanding nutrition authorities who deal with such topics as food buying, nutrition and health, basic elements of nutrition, changing eating patterns. Nutrition problems of older Americans are given prominent comment throughout these discussions. The series will be aired over five major NBC–TV stations during spring and summer 1974. It will then be offered to other television stations and to community groups.

Public Affairs

An emphasis on the needs to solve the problems of elderly Americans has marked many of Mrs. Knauer's public appearances.

In the fall of 1973, Mrs. Knauer addressed a Social Security Administration Forum and took the opportunity to summarize the extreme need for finding solutions to these problems: inadequate food and medical care for low-income older citizens; lack of decent housing for the elderly poor; the overburden of property taxes faced by elderly homeowners; inadequate pension plans and retirement funds; inadequate consumer education and consumer information programs for the elderly.

In the early spring of 1973, Mrs. Knauer held two major press conferences in which she discussed techniques for saving money when food shopping. On both occasions, emphasis was placed on the nutritional needs of elderly people.

Consumer Complaints

During 1973, complaints and inquiries received from senior citizen consumers were divided into these major groupings: inflation/cost of living; cost of drugs; cost of food (as well as quality, packaging and labeling, additives); hearing aids; home repairs; insurance; mail orders; medical services (costs); mobile homes (inability to obtain repairs); television repairs; and taxes.

As with all such letters coming to the Office of Consumer Affairs, individual replies went to each of the older people who wrote to OCA. And, in each case, OCA sent a request to the manufacturer, trade association, retailers, and/or government agency that the inquiry or complaint be answered and/or resolved.

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 1973 these activities included the publication of three editions of the *Consumer Information Index*, distributed to more than 19 million consumers.

Included in the index is much information of use to older consumers, including a number of publications directed specifically to the needs of senior citizens. These booklets are high on the list of those ordered from the Government Printing Office. Further, under a new initiative begun in 1973, the index is now being published in Spanish as well as English, thus affording a special resource for Spanish-speaking older people. In addition, other Federal agencies were urged to translate into Spanish their own publications designed for senior citizens.

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* Retained in committee files.

ITEM 21. POST OFFICE DEPARTMENT

JANUARY 30, 1974.

DEAR MR. CHAIRMAN: We are pleased to furnish for your consideration in preparing your report "Developments in Aging—1973," the following information relating to Postal Service activities that may be of special interest and value to our elderly consumers, which was the subject of your January 3 exchange of correspondence with Postmaster General E. T. Klassen.

The Postal Inspection Service is responsible for the investigative enforcement of the Mail Fraud Statute, Section 1341, Title 18, United States Code. It is the oldest "Consumer Protection Law" ever enacted by the Congress. It provides for a fine of $1,000 or 5 years' imprisonment, or both, for any use of the mails in furtherance of a scheme to obtain money or property on the basis of fraudulent representations.

Confidence in business transacted by mail is regarded as vital to the national welfare. It is the principal, if not the essential, artery of commerce and communication in this country. No elements of our society are immune to loss through mail fraud activity, and the businessman is quite as vulnerable as is the individual consumer. As in the case of all other types of criminal activity, Mail fraud, the "white-collar crime" which leaves a trail of disillusionment and distrust in its wake, attacks the savings, and very frequently leaves the victim with a lengthy time contract to discharge, has shown a steady increase over the past several years. In Fiscal Year 1973, a total of 118,995 complaints were received. Arrests by Postal Inspectors totaled 1,919 and 1,536 convictions were returned; the latter figure representing the highest in history. Some 4,733 questionable promotions were terminated on the basis of our investigations and, although the Mail Fraud Statute makes no specific provision for recoveries, more than $6,000,000 was returned to victims or the public treasury in terms of restitution or fines.

Working with the Postal Service Law Department, the Inspection Service also utilizes two administrative and civil actions, Section 3005 and Section 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.

As in the past, the types of fraudulent schemes encountered in our investigations range from the fly-by-night swindles designed for a quick kill to multimillion dollar financial swindles carefully disguised behind complex corporate structures. Society's demand for protection from these 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 resume of some of those schemes, as outlined herein, as well as related statistics will be of interest to the committee.

Medical Frauds.—Notwithstanding the establishment of modern medical facilities, both mobile and stationary in practically every community in the nation, many elderly people turn to and 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 1973 was over $3,000,000.

Medical fraud schemes are not only wholly false and misleading, but some can also be considered dangerous. Such was the case when 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 one hundred, prevent many maiming diseases, and still cost less than $25.00. 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 one hundred and three questionable promotions in the Medical Fraud category in Fiscal Year 1973.

Solicitation of Funds.—It is well known that many of the elderly are of a compassionate disposition, and often respond to heart rending appeals for contributions to various seemingly worthy causes. Appeals for contributions extend to many causes and include an endless variety of charities and betterment objectives, alleviation of animal suffering, religious and political matters.

There are numerous solicitation 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 large scale businesses, if they are allowed to continue. There were 179 cases issued for investigation by the Postal Inspection Service in the area of solicitations during Fiscal Year 1973 and of this number, 75 promotions discontinued. If these promotions were permitted to flourish, the potential loss would be overwhelming.

Work-at-Home Schemes.—Elderly persons, housewives and others particularly in the poor and lower middle-class income levels, who desire to supplement the family earnings, but find it impossible to hold even as much as a part time job for various reasons, have been increasingly attracted to advertisements for work-at-home employment. Albert J. Maduri, doing business as the CAM Company, was indicted on 20 counts of Mail Fraud, in connection with extensive advertising for work-at-home employment on a nationwide basis. The victims were led to believe that they would be working directly for the CAM Company, mailing out their homework from their homes. Applicants were requested to send a $3.00 fee for their "Starter Kit." After receiving the fee, Maduri furnished the victims information on how to receive work at home by selling the same information to others, thereby creating an endless chain situation. Refunds were made at a ratio of one out of six to stem complaints. Maduri was convicted on February 28, 1973, after the jury deliberated for eleven minutes. He received a five year suspended sentence, five years probation during which he is to refrain from all types of direct mail selling, referral selling, or catalog sales. He was fined $1,000 and required to pay all of the costs of prosecution. Maduri bilked thousands of victims during the four years in which his scheme was operating and grossed over $300,000.

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 Fiscal Year, 151 work-at-home schemes were investigated; of this number, 108 were forced to discontinue their operation. The public loss in these cases amounted to $942,043. Savings to the public because of the discontinuance of these fraudulent operations is estimated to be well over $293,000.

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 Fiscal Year the Inspection Service conducted three investigations into home improvement schemes which resulted in the loss of over $15,000 to the owners. While the number of reported violations is down considerably over previous years, it is felt that an upsurge in the questionable sale of furnaces, insulation, etc. will be seen due to the present energy crisis.

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 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 1973, 160 such investigations caused the termination of 111 chain referral schemes. Public loss in these cases amounted to $3,641,880, while an estimated public saving of $3,235,833 resulted.

One case in point was investigated at Danville, Virginia, where representatives doing business as Eastern States Enterprises sold central vacuum systems on the chain referral plan at a cost to the customers of $895.00, including interest on a promissory note, while comparable systems were selling locally at $370.00. Buyers received few if any commissions. Four defendants in the case were convicted and placed on probation.

Business Opportunities.—There are four separate but closely related promotions falling within this category of cases. These include distributorship, franchises, vending machine and other job opportunity frauds which lure investors with promises of high returns and guarantees of success which later prove worthless. Retired and disabled persons lead the list of individuals who are preyed upon each year to "put their savings to work and supplement their incomes." Vending machine routes are particularly attractive to older retired persons in that supplementing their income in this manner supposedly only requires part-time work.

Investigations were completed in 187 such cases causing discontinuance of 89 questionable operations. Public loss totaled $13,405,900 and an estimated public savings of $3,536,507 was effected.

Land Sale Swindles.—The purchase of land for a future retirement homesite is becoming increasingly popular. Concerted attention to these promotions by Postal Inspectors during recent years resulting in many criminal prosecutions for Mail Fraud, has accomplished a drastic reduction in the number of such schemes with corresponding substantial savings to the public.

One noteworthy investigation involved the sale of 60,125 acres of land, wholly within the Great Smoky Mountains National Park, a Federal Reservation near Asheville, North Carolina. One of the two principals, an attorney, was found guilty of mail fraud and sentenced to five years imprisonment, suspended, and was placed on five years probation, fined $7,000 and ordered to surrender his law license. He certified two false title opinions to obtain title insurance and thus facilitate the sale. The other defendant was likewise found guilty of mail fraud and was sentenced to ten years imprisonment, suspended, placed on five years probation and fined $8,000. The public loss is estimated at $1,250,000.

Matrimonial Schemes.—This is an area where lonely people including the elderly are often swindled by dishonest persons. Lonely people seeking pen pals with a view of finding suitable mates frequently join lonely hearts clubs. Few if any of these clubs have facilities for investigating persons applying for membership and it is said that lists of members can be purchased with little or no difficulty. Club membership lists are therefore sometimes obtained by unscrupulous persons who use them to carry on extensive correspondence with prospective victims.

The correspondence is usually started by the promoter's misrepresenting themselves to be exactly what the club members desire in mates. As the correspondence progressed endearing terms are used and when the prospective victim mentions matrimony the promoters talk of current financial problems and request sums of money to carry them over the temporary crisis. Once the money is received the promoter usually fails to answer additional correspondence or returns the letters marked "moved," "left no address." Many victims fail to report the matter because of embarrassment.

Public Education and Fraud Preventive Program.—The Inspection Service has continued to expand its program to prevent frauds through developing greater public awareness as to its danger signals. During Fiscal Year 1973, Postal Inspectors made over 1,000 speaking appearances before law enforcement, civic, educational and consumer groups. Further, wide distribution was made of the mail fraud pamphlet, a copy of which is attached for your information.* We con-

* Retained in committee files.

tinue to maintain close liaison and exchange mutually helpful data and intelligence with numerous agencies concerned with consumer protection which we consider to be highly beneficial. 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 trust this summary will be helpful to you and your committee. If we can be of any further assistance, please do not hesitate to contact me.

Sincerely,

JOHN W. POWELL,
Congressional Liaison Officer,
Government Relations Department.

ITEM 22. RAILROAD RETIREMENT BOARD

JANUARY 28, 1974.

DEAR MR. CHAIRMAN: With reference to your letter of December 21, we are pleased to enclose the attached statement summarizing major activities of the U.S. Railroad Retirement Board on aging during 1973. It is anticipated that payments to older Americans during 1974 under the Railroad Retirement Act will be somewhat higher than during 1973 and those under the Railroad Unemployment Insurance Act will be at approximately the same level as during 1973.

We look forward to your committee's 1973 report on developments in aging.

Sincerely yours,

R. F. BUTLER,
Secretary.

[Enclosure]

U.S. RAILROAD RETIREMENT BOARD

The U.S. Railroad Retirement Board is the Federal agency that administers a social insurance system, separate from but coordinated in several ways with Social Security, for railroad workers and their families. Programs of the system include the following: (1) old age, survivor and disability benefits under the Railroad Retirement Act and (2) unemployment and sickness insurance benefits under the Railroad Unemployment Insurance Act. In addition, certain administrative services under the Federal health insurance (Medicare) program are performed with respect to aged and disabled railroad workers.

DEVELOPMENTS IN 1973

LEGISLATION

Two separate pieces of railroad retirement legislation (Public Law 93-58 approved July 6, 1973, and Public Law 93-69 approved July 10, 1973) were signed by President Nixon during 1973.

Public Law 93-69 is by far the more important law, including and providing a timetable for certain amendments to the railroad retirement system mutually agreed upon and jointly recommended by railroad management and labor. These amendments (1) extended the temporary increases in railroad retirement annuities of 15 percent, 10 percent and 20 percent enacted by Congress in 1970, 1971 and 1972, respectively, through December 31, 1974; (2) revised employee and employer tax rates, effective October 1, 1973, under the Railroad Retirement Tax Act to reduce the employee rate to the percentage rate paid by employees in Social Security employment and to increase the employer rate so that the total tax income is maintained at the level in effect before the change; (3) permitted retirement on unreduced annuities, effective July 1, 1974, of all employees who are at least 60 years of age and have 30 years or more of creditable railroad service; (4) provided that railroad retirement annuitants who would not otherwise have their annuities increased as a result of increases granted Social Security beneficiaries during the period July 1, 1973 to December 31, 1974, would receive the same dollar increases that they would have received if they were covered under the Social Security system; and (5) instructed railroad management and labor to continue their negotiations concerning a

revamped railroad retirement system which would become effective no later than January 1, 1975.

Public Law 93-58 amendments (1) adopted certain eligibility liberalizations for children's annuities under the railroad retirement system in order to conform with Social Security changes enacted in 1972 and (2) extended Medicare coverage for the treatment of kidney disease to railroad employees and retired employees and their spouses and dependent children. In addition, certain technical modifications of Social Security Act definitions were added to the Railroad Retirement Act.

BENEFICIARIES AND BENEFITS

During fiscal year 1973, benefit payments under the railroad retirement and railroad unemployment insurance programs totaled $2,530 million, an increase of $288 million over the preceding year. In addition, payments of $240 million for hospital insurance benefits and $77 million in supplemental medical insurance benefits were made on behalf of railroad workers under the Medicare program.

Retirement and survivor benefits amounted to $2,457 million, some 16 percent more than the total paid in fiscal year 1972. Unemployment and sickness payments in the year totaled $73 million, $47 million less than in the preceding year.

About 1,070,000 persons received benefits under the retirement program, including 29,000 who received more than one type of benefit. The vast majority of these individuals (about 85 percent) were aged 65 and over.

The 448,000 retired employees as of June 30, 1973, were being paid an average regular annuity of $269, an increase of $49 from a year earlier. In addition, 106,000 or 27 percent of all retired employees age 65 and over were being paid supplemental annuities which averaged $65.

About 858,000 persons who were receiving or were eligible to receive monthly benefits under the Railroad Retirement Act were covered by hospital insurance under the Medicare program at the end of fiscal year 1973. Of these, 834,000 (97 percent) were also enrolled for supplemental medical insurance.

Benefits under the Railroad Unemployment Insurance Act were paid to 169,000 railroad employees. However, only about $1 million (1.4 percent) of the benefits went to individuals aged 65 or older.

ITEM 23. SMALL BUSINESS ADMINISTRATION

FEBRUARY 22, 1974.

DEAR MR. CHAIRMAN: This will acknowledge your request with reference to the Annual Report of the Senate Special Committee on Aging.

You will recall that your last report made no mention of the Small Business Administration. The services of this agency are available to small businessmen regardless of age. Regrettably, we have no figures available as to the percentage of our loans which are made to businesses where the principal is age 65 or older. Our SCORE (Service Corps of Retired Executives) program is an effort to utilize the business acumen of senior citizens, but we presume that ACTION will report on this endeavor since SCORE is now a part of that agency.

The only other aspect of aging to which we direct our attention is the disaster loan program. It is agency policy that age not be a factor in any disaster loan application declination. If an elderly person's home is destroyed in a disaster, all other things being equal he receives a disaster loan as rapidly as a 30-year-old.

With all good wishes.

Sincerely,

THOMAS S. KLEPPE,
Administrator.

ITEM 24. SOCIAL SECURITY ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., February 11, 1974.

DEAR MR. CHAIRMAN: In further reference to your letter of December 21, 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—1973" report.

Sincerely yours,

ARTHUR E. HESS,
Deputy Commissioner.
(For the Commissioner.)

[Enclosure]

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration administers the Federal retirement, survivors, disability, and health insurance programs (titles II, VII, XI, XVI, 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. (It administers the Federal Supplemental Security Income (SSI) program for the needy aged, blind, and disabled (title XVI) beginning 1974.)

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 aged 65 or over and to certain disabled persons. About 79 million persons were working in employment covered under the Social Security program in September 1973. Nine out of ten of the population aged 65 and over were either receiving or were eligible to receive cash benefits at the beginning of 1973; among those reaching age 65 during 1973, the proportion who were eligible for benefits was 93 percent. Most persons aged 65 and over have coverage for hospital benefits under Medicare, and a slightly smaller number are enrolled for Medicare's supplementary medical benefits.

DEVELOPMENTS IN 1973

LEGISLATION

Public Law 93–66, signed by President Nixon on July 9, 1973, amended several provisions of the Social Security Act relating to the monthly cash benefits program: effective January 1974, the annual exempt amount of beneficiaries' earnings was raised to $2,400 (a beneficiary may earn $200 in a month and still get full benefits for the month); the maximum taxable and creditable amount of earnings was raised, effective for taxable years after December 31, 1973; and monthly cash benefits were to be increased, starting with the June 1974 benefit. Public Law 93–22, signed by the President on December 31, 1973, revised the earlier change in the annual taxable earnings, raising it to $13,200, effective January 1974. It also revised the scheduled benefit increase of 5.9 percent providing instead for an 11-percent increase in two steps—7 percent payable with the March 1974 benefit and 4 percent payable with the benefit for June. The December legislation also changed the provision for delayed retirement credit; the special minimum benefit for workers with many years of low earnings in covered employment (raising from $8.50 to $9 the amount of increment payable for each year of coverage above 10 years up to 30); and the automatic adjustment provisions for benefit increases and for the retirement-test exempt earnings. The total Social Security contribution rate was not raised, but a shift in the shares for cash benefits and the hospital benefits reduced the latter by 0.1 percent and raised the rate for the cash benefits by 0.1 percent for 1974–77. The amendments also revised some provisions for the Supplemental Security Income program and some technical provisions for Medicare and Medicaid.

BENEFICIARIES AND BENEFITS

More than 29.7 million men, women, and children were receiving monthly Social Security benefits at the end of November 1973. About 18.6 million of these beneficiaries were retired workers and their dependents. In addition, approximately 362,400 uninsured persons aged 72 and over were receiving monthly payments (from the Social Security trust fund but financed primarily from general revenues). The remaining beneficiaries were disabled workers and their dependents or the survivors of deceased workers.

During fiscal year 1973, benefits paid under the retirement, survivors, and disability provisions of the program totaled $47.3 billion. Of that amount, $311.1

million represented lump-sum death payments, monthly benefits for retired workers and their dependents and for survivors totaled $41.8 billion, and benefits for disabled workers and their dependents amounted to $5.1 billion. For November 1973, the monthly rate of benefits was $4.2 billion—at an average benefit amount of $166 for retired workers and of $183 for disabled workers. For persons newly coming on the rolls that month, the average award was $172 for retired workers and $198 for disabled workers.

Under the "black lung" program, benefits were being paid in November 1973 to 417,000 persons—147,000 miners and 270,000 dependents. The total amount being paid was $58,600,000, and the average family payment was $221.00.

MEDICARE OPERATIONS

Approved claims under the hospital insurance part of Medicare totaled 5.7 million during the first 10 months of fiscal year 1973. Almost nine out of ten of these claims were inpatient hospital claims, and the average amount reimbursed for such claims was $876. Hospital benefits are financed by contributions paid as part of the total Social Security contribution (in 1973 at a rate of 1.0 percent of covered earnings). Persons aged 65 and over and not otherwise eligible for hospital benefits under Medicare may voluntarily enroll for these benefits and pay a monthly premium ($33 a month for the calendar year 1973). During the fiscal year 1973, $6.6 billion was withdrawn from the hospital insurance trust fund for services under the program.

The medical insurance part of the program had 48.3 million claims recorded for fiscal year 1973. Of these claims, 80 percent were for physicians' services. Allowed charges totaled $2.9 billion, and $2.1 billion or 73 percent of that amount was reimbursed. The program is financed by monthly premiums paid by those electing to be covered and matched by the Federal Government. The monthly amount of the premium was $5.80 from the beginning of 1973 until August 1973, when it rose to $6.30; it will rise again in July 1974—to $6.70.

Beginning July 1973, Medicare coverage was extended to the disabled under age 65 who have been entitled to Social Security benefits for 2 years or more and to insured workers and their dependents who need dialysis treatment or a transplant because of chronic kidney disease. Several amendments relating to reimbursement of providers were included in the December 1973 legislation. Additional technical amendments affect: The continuation of State buy-in agreements for medical benefits under Medicare as SSI goes into effect; clarification of disposition of savings realized by health maintenance organizations (HMO's); and certification requirements when hospitalization is required in connection with noncovered dental procedures.

SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

In January 1974, the Social Security Administration began operations under the new Federal Supplemental Security Income program for the aged, blind, and disabled, as the State-Federal assistance programs for these categories of low-income persons were discontinued. Planning for this changeover was conducted during 1973. The Social Security Act amendments passed in July and December 1973 revised several provisions of the SSI original legislation. The major changes included the setting of new payment levels—at $140 a month for an individual and $210 for a couple, effective for January 1974, and the scheduling of further increases effective for July 1974 to $146 for an individual and $219 for a couple. The July legislation contained provisions to protect recipients on State assistance rolls from any possible reduction of income resulting from the new program or, for certain persons, from loss of Medicaid eligibility. The December law broadened and clarified some of these provisions. It also suspended for 6 months the provision prohibiting SSI recipients from participation in the food stamp and surplus commodities program.[1] Other December amendments relate to the States' fiscal liability for payments supplementing the SSI payments and to the period during which States must assist in implementing

[1] Except that in eight States (California, Hawaii, Massachusetts, Nevada, New Jersey, New York, Rhode Island, and Wisconsin) that have included the value of food stamps in determining their adjusted payment levels for purposes of State supplementation and that receive Federal funds, SSI recipients will be ineligible for food stamps or surplus commodities.

the SSI program. Several provisions in the area of Medicaid-SSI eligibility were also enacted.

Social services

Under SSI, the States will continue to provide social services. The Social Security Administration, the Social and Rehabilitation Service, and State welfare organizations are working to increase the effectiveness of the linkages between the Social Security Administration offices and State and local service agencies, and they are focusing on the more intensive social service needs of SSI beneficiaries. One objective is to meet these needs through mechanisms that minimize the referral of individuals from place to place. In this connection, social service personnel will be stationed in selected Social Security district offices to determine the effectiveness of such an arrangement, particularly in the task of finding assistance for the critical and immediate social service needs of the SSI applicants.

ITEM 25. VETERANS ADMINISTRATION

JANUARY 30, 1974.

DEAR MR. CHAIRMAN: In response to your request of December 21, 1973, I am pleased to forward the enclosed report on Veterans Administration activities relating to developments in aging for the year 1973.

As you know, this Agency has a significant interest in our aging population. Two-thirds of the more than 29 million veterans in this country have passed their fortieth birthday, and more than two million are 65 years of age or older.

The magnitude of our activity is indicated by the fact that currently the VA provides all or part of the income of more than 1.7 million persons age 65 and over. Also on a "typical" day in the VA-supported inpatient institutions (i.e., hospitals, nursing homes, and domiciliaries) more than 30 percent of our inpatients—about 36,000 veterans—are age 65 and over.

We are currently involved in a number of important geriatric research studies which hopefully will result in improving the health and living capabilities of our older population.

I hope that the attached information will be helpful to the committee. Please let us know if we can provide any further aid.

Sincerely,

DONALD E. JOHNSON,
Administrator.

[Enclosure]

VA ACTIVITIES AFFECTING OLDER VETERANS IN 1973, DEPARTMENT OF MEDICINE AND SURGERY

1. INTRODUCTION

The Veterans Administration program for care of the aging has moved into an accelerated phase of planning and accomplishment. Solid gains were made during the past year in the clinical phases of the program in terms of increasing the number of beds devoted to the care of the aging and expanding the facilities for their outpatient treatment. Also the VA was able to map and begin operations in the following new areas of emphasis: The creation of new geriatric research and clinical centers, the firming up of linkages with gerontology institutes, and coordination with the Administration on Aging in the development of areawide model projects in aging.

The first of these areas concerns the creation of approximately six new geriatric research and clinical centers of VA hospitals. These hospitals will be chosen on the basis of their interest and capability in clinical and research approaches to geriatrics. The centers will emphasize broad new efforts encompassing biomedical and behavioral technologies and will seek to decrease the gap between research and clinical application.

The second area of interest seeks to affiliate the VA with known centers of excellence among established gerontology institutes in order to share expertise and prevent unnecessary duplication in education and research areas. We have had field visits to the Ethel Percy Andrus Institute of Gerontology in Los Angeles and the All-University Gerontology Institute of Syracuse University. Conversa-

tions have been held and visits are planned with several other institutes, including the Duke University Institute of Gerontology and the Faye McBeath Institute of Gerontology at the University of Wisconsin.

Third, the VA has cooperated with the Administration on Aging and the Long-Term Care Division of the Department of Health, Education, and Welfare in making field visits to the PIMA County Council on Aging in Tucson, Ariz., and the All-University Gerontology Center in Syracuse, N.Y., to achieve better integration in the planning for the aged both in the community as a whole and in the VA itself. As an example of what can happen, the VA Hospital in Tucson has been hosting day-care sessions for the PIMA County Council on Aging.

With respect to education and training, the VA held a conference in Palo Alto, Calif., in June of 1973 on "The Caring Environment—A New Approach to Aging," in which three foci were discussed: Death and Dying, Self-Destructive Patterns of Patient Behavior, and Institutional Patterns of Dehumanization. About 200 administrators of long-term care non-VA facilities were present. Similar conferences will be held in St. Louis, Mo., and Bay Pines, Fla., this year.

The VA has increased its liaison with other Federal and voluntary agencies and is represented by the Deputy for Clinical Services of the Department of Medicine and Surgery on the Interagency Task Force on Aging, the National Advisory Council for Child Health and Human Development, and the National Council on Aging.

2. Medical Service

The Medical Service is significantly involved in the care of patients with chronic illness. A survey conducted in 1973, revealed that approximately half of all Medical Service beds were occupied, on the average, by patients with illnesses requiring more than 30 days of hospitalization. Diseases of the central nervous system, heart, lungs and the musculo-skeletal system were the most frequent diagnoses. Multiple diagnoses were often encountered in individual patients, and their physical health was often adversely affected by advanced age, infirmity, and unfavorable socioeconomic circumstances.

Medical Service has employed the survey results in its efforts to significantly upgrade the care of its long-term patients. Initial efforts have concentrated on refining and expanding the results of the survey, and in additional studies of individual aspects of long-term care.

Our preliminary results support the contention that long-term care appears to be optimal when it is fully integrated with the delivery system for the acute and the ambulatory patient. However, the unique needs of the older patient must be better defined and more adequately met in the future. Towards this end, Medical Service is planning to devise, with appropriate consultation, a series of programs directed towards solution of the most common medical and health-related problems encountered in its long-term care patients. These efforts will include generation of data concerning the need for additional resources for the proper implementation of these programs. In the interval before these programs become operative, we are encouraging the field station Medical Services to meticulously review the health care they provide to long-term patients with a view towards detecting weak points and correcting remediable shortcomings. It is anticipated that such a review will prompt some cogent contributions to our overall efforts in the area and will provide a receptive ground for further innovation.

It is anticipated that our studies of long-term care at VA hospitals will be completed during the next fiscal year, and that recommendations based on these studies will then be made. Implementation of these recommendations will be pursued at the most rapid pace permitted, since it is apparent that the comprehensive care of long-term patients is a major component of the overall responsibilities of Medical Service.

3. Mental Health and Behavioral Sciences Service

One of the ways in which the VA Mental Health and Behavioral Sciences Service can develop effective treatment for problems experienced by older veterans is by learning more about the social, psychological and health characteristics of this group. During the past year a study was conducted to obtain normative data concerning the additudinal and life-style characteristics of the total patient population in VA hospitals, clinics, and domiciliaries. This type of information has relevance to many of the questions and problems focusing around

the treatment and rehabilitation approaches for patients of various ages confronted by a range of medical or psychiatric conditions.

Another way in which the VA can increase the effectiveness of treatment programs is through research. A comprehensive review of a variety of behavioral research studies related to the aging process itself, such as memory changes, is presented in another section of this report. One study of special interest being developed by the Mental Health and Behavioral Sciences Service concerns the considerable number of older persons who experience symptoms of cerebral impairment in varying degrees. The effects of organic brain syndrome can be seen in residents in VA nursing homes, intermediate medical services, domiciliaries and outpatient facilities. As part of its continuing efforts to assess new forms of treatment, the VA Central Neuropsychiatric Research Laboratory is developing the baseline data and instruments necessary to begin a collaborative study evaluating several forms of chemotherapy in patients with chronic organic brain syndrome.

Still another way in which more effective programs for elderly veterans can be developed is through continuing education of staff personnel who work with geriatric patients. Last year such efforts were highlighted during the 18th annual conference of Veterans Administration Studies in Mental Health and Behavioral Sciences held in New Orleans March 28–30, 1973. A major symposium at that conference was entitled "Therapeutic Efficacy in the Treatment of Senility: Fact or Artifact?" Represented in the panel was a distinguished group from psychology, psychiatry, neurology, biochemistry, and rehabilitative medicine. Additionally, at the same conference, a teaching seminar was presented entitled "Pills versus Programs for the Aging: Questions for Research." Each of these approaches: (1) Learning more about the characteristics of elderly veterans, (2) research, and (3) education and training of staff personnel, will be continued by the Mental Health and Behavioral Sciences Service during 1974 to improve the delivery of health services to aging veterans.

4. 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, 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.

In fiscal year 1973, VA Social Work Service assisted 21,148 veterans in VA general hospitals to secure a change in their living situations by placing them in personal care homes, nursing homes, domiciliaries, state soldier's homes, boarding homes and other special residences. Of the 21,148 veterans, 19,251 veterans were age 40 and over; 5,260 were in the age range of 40–59; 4,009 were in the age range 60–69; and 9,982 were 70 and over.

VA hospital teams inspect and affirm the suitability of community homes prior to placement efforts on behalf of veterans, provide consultation and offer training opportunities to sponsors and caretakers. Social Work Service carries major responsibility for continued provision of supportive services to these veterans as needed. Seven regional workshops with representation from each medical district were held to explore alternatives to institutional care for aged, chronically ill veterans. As a result, several VA hospitals have expanded their community and home care programs in cooperation with local agencies.

Veterans returning to their own homes in isolated areas or those veterans who live alone are being contacted by phone at specified times under a program called Telecare and run by volunteers. If the veteran doesn't answer, help is sent to the home to determine what has happened. Social workers in over 100

hospitals are involved in developing and supervising such programs or using similar programs operated by community agencies. Friendly visiting by volunteers to the aged living alone or in nursing homes is another approach used by an increasing number of VA hospitals.

An increasing concern of VA focuses around the services needed by the terminal, older veterans. As a result of advancing medical knowledge and life-extending procedures more veterans are reaching old age than ever before and in line with a national trend, more older veterans are dying in the VA hospitals and nursing homes. This trend has led to VA's examination of the quality of dying in the hospitals and a resolve to help patients and families deal with the problems presented in a more responsible and humane way. Social workers, nurses, chaplains, psychologists and others are actively involved in this developing program. Several VA hospitals including those at Palo Alto, Minneapolis, and Little Rock have established special catastrophic illness programs. Accent is on helping hospital and nursing home staffs face, understand and cope with their own and the veterans' anxieties, fears, attitude, and behavior toward death.

Social Work Service plans to' increase its involvement with university gerontological centers, schools of social work and community agencies concerned with the aged in the areas of service delivery, training and research. Continuing emphasis is being placed on regionalized approaches to the care of the aged and to upgrade social support systems which will assist the aged in maintaining appropriate living situations in the veterans own community.

5. Rehabilitation Medicine Service

Rehabilitation Medicine Service throughout the VA system places considerable emphasis on treatment and activity programs for the older veterans. These range from special programs for treatment of physical dysfunction problems to socialization programs for the older individual, community orientation programs, Work-for-Pay hospital service programs, conjoint programs with local community agencies, involvement in Headstart programs, active participation in Nursing Home Care Unit Programs, Reality Orientation emphasis, and many others.

The Director, Rehabilitation Medicine Service in VA Central Office, serves as a member of the advisory committee to the American Hospital Association Reality Orientation Project. The objective of the project is to develop Reality Orientation training material to use with the confused elderly throughout the country. Many Rehabilitation Medicine Services are using RO treatment techniques in nursing home care units, programs for geriatric patients, and also in programs for brain-damaged individuals.

An outstanding example of a hospital community project for older patients is the St. Cloud VA Hospital-Westwood School Remotivation Project. The program is concerned with a sixth grade class at the Westwood School in St. Cloud and geriatric patients at the VA Hospital. Half the class participates in the fall semester and the other half in the spring. The students and patients meet twice weekly for the course of the semester with a student and patient being paired together. Topics covered during the semester include friendship, pets, letter writing, food, etiquette, cake baking, restaurant, clothing, parties, etc. The program was developed in Rehabilitation Medicine Service and has proven to be an excellent experience for both the young people and the older patients.

A number of recreation programs in VA hospitals have been instrumental in introducing patients into senior citizen activities in the community as part of recreation counseling and community involvement programs. One of the significant areas for Rehabilitation Medicine Service is the extension of services into the community to help inpatients and outpatients identify the availability of community resources.

Special geriatric calisthenic and exercise programs have been developed and used in VA facilities in which attention is paid to the exercise needs of older patients.

Mobility and involvement throughout the life span are important principles underlying Rehabilitation Medicine Service programs throughout the VA. Special attention is paid to the importance of insuring that Rehabilitation Medicine Service programs for older citizens are dynamic and varied. Much needs to be done to develop these programs more fully. It is anticipated that many Rehabilita-

tion Medicine Service personnel will be participating in the various gerontological institutes throughout the country, both to learn new concepts in the treatment of the elderly, and also to share the knowledge they have.

6. Dietetic Service

Nutritional care is an essential component of total health care and encompasses many aspects of the aged veteran's total treatment program. Since food habits of the aged are firmly established, flexibility in planned meals allows the geriatric veteran to select foods within the limits of his prescribed modality of dietary treatment while catering to his individual food preferences. For example, in the VA nursing home care units selective menus are encouraged and whenever possible modifications of the normal (regular) diet are kept to a minimum. Emphasis is placed on independent thinking in food selection while insuring that nutritional requirements are met. Socialization during meal service is emphasized by providing dining room settings within the unit. Food service in close proximity to patient units contributes to maintaining acceptable temperature of the food served and allows greater freedom in accommodating patient requests for menu changes. These efforts to provide a desirable mealtime situation for the aged have encouraged them to eat more adequately, thus satisfying both their physical and psychosocial needs.

Self feeding limitations due to paralysis, feebleness and poor eyesight are a contributory factor to the poor eating habits of the geriatric patient. With the use of eating aids, such as rim guards for plates and appropriate eating utensils, the aged veteran is better able to retain independence during mealtime and require minimum alterations in food consistency.

Nutrition education begins early in the older veteran's hospitalization. Emphasis is placed on adequate food selection to meet individual nutritional requirements. Innovative approaches to patient education, such as Diner's Club have been successful. The dietitian arranges to have lunch with selected patients in the personnel cafeteria. During mealtime, she encourages discussion centered on the adequacy of the meal selected by the patients. Followup luncheons with these patients indicate improved knowledge of nutrition based on appropriate food selection and increased food intake.

Dietitians participate in interdisciplinary conferences to plan for patients' discharge. Goals are established to train the patient to be responsible for his nutritional care thus avoiding readmission to the hospital and inappropriate institutionalization. Aged veterans living alone are subject to nutritional problems and require special attention prior to discharge. Many are not able to cook and those who do lack interest in cooking for themselves. Education programs for these patients include instruction on normal nutrition, budgeting, shopping, simple cooking procedures and use of convenience foods. Handicapped geriatric patients, such as post stroke patients are prepared to return to the community through rehabilitation in the Group Living Improvement Program. In a rehabilitation kitchen, these patients are taught simple food preparation techniques, incorporating use of preprepared and partially prepared ready foods, and are given information on food budgeting and purchasing. To insure continuity of their care, the aged are given information on nutritional resources, such as the Meals-on-Wheels Program and Home Health Aide Program, available in their local community.

Dietitians as active members of the community placement team visted community nursing homes and other community care residences, such as personal care homes and foster homes to evaluate the adequacy of the veterans' nutritional care and make recommendations for improvement as needed.

Sponsors of community care residences were invited to attend nutrition education sessions at VA hospitals to assist them in planning adequately for the nutritional care of aged veterans. Classes were given in menu planning, food purchasing and preparation, sanitation, and special diet requirements, to assure adequacy of the veterans' food intake and assist the aged to maintain ideal weight levels.

Visits to the veterans' homes were scheduled by the dietitian to provide post hospital care in the Hospital Based Home Care Program. Caretakers were counseled on the patients' special nutritional requirements, and assistance was given on various aspects of food purchasing and preparation. Followup visits were made to assess adherence to diet modifications and nutritional status of patients.

Feedback information on nutritional adequacy of care was provided other health care team members involved in the patients' total treatment plan.

7. 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. Nurse administered units are established in selected long-term care settings, in which nurses practice in an expanded role and assume primary responsibility for the continuum of care in health maintenance, management of symptoms, and referral to alternate care settings.

The written nursing care plan includes an assessment of each veteran's nursing needs and a plan of 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 physical environment. Trips to laundromats, dry cleaning establishments, departments 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 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 followup 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 followup 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 work as a person, a member of the family unit, and a member of the community.

The service's objectives for the future are to demonstrate the contributions that nurses in an expanded role are making to improve care for the aged in a variety of settings: and to explore the influence of environment on the therapeutic program.

8. Voluntary Service

The VA Voluntary Service has always considered the older citizen as a fine prospect for its program of volunteer assistance which contributes to the comfort and welfare of veteran patients both within the hospital and in the community. The high number of awards given to those who have contributed 15,000 hours and above attest to the esteem the VA has for the older persons who contribute their services.

This last year the VA Voluntary Service has worked closely with ACTION's Older American Volunteer Program. The mutual coordination and cooperation at both the national and local levels have proved to be mutually beneficial. More importantly, these efforts have enabled more older persons to take advantage of opportunities to occupy their time, skills and talents for the benefit of others.

The VA Voluntary Service Program does not have a special category of volunteer assignments especially designed and set aside for the senior citizen. Age is not the decisive factor. The VAVS program does make every effort to match the interests, time available, and abilities of the older person with the various categories of volunteer assistance needed to supplement and extend the work of hospital staff for the benefit of the patients. A very positive attribute of the older persons is that often they have had the kind of experience and knowledge which generates volunteer assignments not previously considered. With time available and without the pressure of full time employment, older persons can undertake special projects not only beneficial to others but which also liven their own existence. They thus constitute a respected and valued component of the VA Voluntary Service Program.

9. VA Medical Research in Aging—Fiscal Year 1973

During fiscal year 1973, the VA conducted 144 research projects designed to learn more about the physiology and pathology of aging, generally defined as progressive changes produced with the passage of time. The level of funding for individual projects in aging research of $2.7 million has been sustained for the past 2 years.

Investigators in the normative aging study at the VA Outpatient Clinic, Boston, Mass., have developed a scientific technique to measure functional age for comparison with chronological age, and have presented it to the Gerontological Society. When this study is completed they will have determined, if successful, what changes in visual, hearing, memory, physical exercise, and other vital functions may be expected to occur during certain periods of time as, for example, the "decades" of age. The normative aging investigators are studying 2,032 participants and report that their attrition rate during the past year is less than 1 percent.

The relation of aging to the function of memory was more widely investigated than any other single function during the year. Findings indicated that memory function in aging patients was not so deficient as previously thought. There was encouraging evidence that proper care, training and treatment may modify the degree of decreased memory function that actually transpires with aging. The normative aging study has accumulated significant statistics on the performance of a group over a 50-year span from ages 20 to 70, on the time needed to learn, store, and retrieve ability to classify stimuli ranging from simple to complex, under easy and difficult rules. At Bay Pines, Fla., a VA study showed that formation of associations was most relevant to learning a serial list of words and resulted in better performance than anticipated.

The human cell is fundamental to the study of physiology or pathology of aging. Basic scientists at the VA Hospital, Bedford, Mass., studied the fibroblast in depth, both in life and in the test tube. The fibroblast is a connective tissue cell that differentiates to form cartilage, bone, tendons and fibrous tissues that support and bind together the wide variation of body tissues. They found that most normal, human fibroblasts exhibit marked cellular changes and cease to grow after 50 to 70 cell divisions. Many investigators choose these cells as models for aging studies. One study demonstrated that diploid cells (those with two sets of chromosomes) cultured in a test tube, lived proportionately shorter periods as the age of the donor was advanced. Fibroblasts from children with premature aging diseases have a noticeably reduced potential of cellular division very similar to fibroblasts from adults with premature aging syndromes. The limited life-span of these cells appears to be related to aging, but the search continues to find the mechanism of senescence in these cells which should be relevant to the aging process.

Relating laboratory studies to life, they investigated the large molecules in connective tissue from the beginning of life to life's end. Changes in quality and quantity of these tissues during aging is well-documented. Investigators studied diploid fibroblasts from skin which changes with age in a manner apparent to the casual observer. At the molecular level, these aging changes result from a disappearance of soluble collagen, an albumin-like protein which is the principal supportive substance of connective tissue, and a decrease in hyaluronic acid, the cement substance of the tissues. In mature tissue, collagen is a well-organized network. With age, it develops a cross-linkage that tends to become more insoluble. What is observed to take place in life may be double-

checked in the test tube for final proof. The Bedford group reports that evidence in the laboratory, and in life, supports the hypothesis that the limited proliferation of fibroblasts and the increased insolubility of their principal protein substance, collagen, is directly related to the aging process. They are progressing further into understanding more complicated changes in biochemistry associated with aging.

Veterans of advanced age are besieged with a number of chronic ills, such as atherosclerosis, pulmonary and gastrointestinal disorders, diabetes, obesity, diminishing sight and hearing, and some acute disorders that may develop after long chronic ill health. Most of these problems may be alleviated through proper nutrition. The elderly require more vitamins; more protein and less carbohydrates in their diets to lower lipid (fat) content in the blood.

A leading danger are the strokes and heart attacks that are critically disabling, if not fatal. The VA is spearheading a nationwide program to find persons who have high blood pressure, which can be successfully treated, but if untreated leads to the destruction of the vascular system, blockage of circulation, and serious damage to such vital organs as the kidneys, brain and heart. An awareness of this danger at all levels is largely due to the VA cooperative study that proved to the medical world that antihypertensive drugs will manage high blood pressure, and the treatment should begin as soon as high blood pressure is detected in the aging veteran.

Kidney failure is the fourth leading cause of death. In addition to finding successful management of some kidney diseases by drugs, the VA has pioneered the transplantation of kidneys, and hemodialysis which prolongs life after kidney failure. During the past year, 2,000 veterans received hemodialysis for kidney failure and 15 VA hospitals performed 214 kidney transplants. The hemodialysis facilities will be expanded to care for an estimated 6,500 veterans by 1978. A serious disability of aging is the loss of calcium from the skeletal system resulting in serious and frequent fractures of bones. This condition is much worse in patients who have kidney disease. Massive doses of vitamin D, which should cause the absorption of necessary calcium from the diet, are of no help in these cases. Investigators at the VA Hospital Center, Los Angeles (Wadsworth), Calif., discovered that vitamin D is chemically changed by healthy kidneys to an active hormone (D–125). Diseased kidneys cannot change vitamin D to D–125. Dialysis patients were afflicted with this condition. Given 100 units of D–125, their metabolism normally absorbed sufficient calcium thus bone calcium deficiency was erased.

Proposed new studies for fiscal year 1974 include the measurement of elasticity of the skin as an index of aging; assay of testosterone and cyclical AMP (a master hormone) to explain endocrin-triggered metabolic changes with age; cardiovascular function study involving exercise stress, electrocardiography and measurement of oxygen saturation in the blood by nontraumatic ear oximetry; immunoglobulin changes with age related to effective resistance by the immune system to infectious disease; a study of cardiovascular aging as depicted by measurement of elasticity of the microvascular system; and a clinical and radiological study of rheumatism and arthritis.

Six clinical and research centers for aging are planned for the following VA hospitals, centers, and outpatient clinic, which have active research programs in aging: Palo Alto, Calif., Bay Pines, Fla., Boston OPC/Bedford, Mass., Little Rock, Ark., Los Angeles (Wadsworth), Calif., and St. Louis, Mo.

DEPARTMENT OF VETERANS BENEFITS

1. 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 1,702,869 persons age 65 and older. This total is broken down to 826,320 veterans, 703,468 widows, 132,131 mothers and 40,950 fathers of veterans.

2. Veterans Assistance Service

In 1973, the Veterans Assistance Service-Guardianship activity completed its second full year of application of supervised direct payment procedures whereby

marginally functioning VA beneficiaries, persons classified as incompetent but deemed borderline between competency and incompetency, are paid direct with supervision. When payments are made directly to such incompetent beneficiaries, frequent personal contacts are made to evaluate their status. If a beneficiary deteriorates to the point where a fiduciary is necessary, one is obtained. On the other hand, if a beneficiary improves to the point where a competency classification seems in order, effort is made to have him so declared. Supervised direct payment procedures are providing the degree of assistance the individual beneficiary requires and still leave him a free and unencumbered member of society.

These supervised direct payment procedures were implemented in October 1971. As of November 30, 1973, there were 2,257 adult beneficiaries, or 2 percent of the total 113,400 incompetent adult beneficiaries, who were being paid under supervised direct pay.

3. Educational Assistance

There are about 900 people over age 65 receiving Veterans Administration educational benefits. Six hundred seventeen persons are attending training under chapter 34, title 38, United States Code, receiving benefits designated by the Veterans Readjustment Act of 1966 as amended. In addition, 109 widows of veterans who died of service-connected causes and wives of veterans who are permanently and totally disabled from service-connected disabilities are enrolled in the education program under chapter 35. About 200 are recipients of vocational rehabilitation benefits under chapter 31.

APPENDIX 2

COMMITTEE HEARINGS AND REPORTS

No asterisk indicates single copy available from committee and multiple copies available for purchase from U.S. Government Printing Office.

One asterisk indicates committee's supply exhausted; copies are available for purchase from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

Two asterisks indicate all supplies exhausted. Libraries designated as "Depository Libraries" receive printed or microform copy of all Government publications for inter-library loan and reference service.

Three asterisks indicate limited quantity, single copy available from committee supply.

With a request for printed copies of documents, please enclose self-addressed label for each item desired.

Action for the Aged and Aging, Report No. 128, March 1961.**

Action for the Aged and Aging, summary and recommendations of Report No. 128, 1961.**

Developments in Aging, 1959–63, Report No. 8, February 1963.**

Developments in Aging, 1963–64, Report No. 124, March 1965.**

Developments in Aging, 1965, Report No. 1073, March 15, 1966.**

Developments in Aging, 1966, Report No. 169, February 1967.***

Developments in Aging, 1967, Report No. 1098, April 1968. (Cat. No. 90/2:S. Rept. 1098, $1.25)*

Developments in Aging, 1968, Report No. 91–119, March 1969. (Cat. No. 91/1:S. Rept. 119, $1.25)**

Developments in Aging, 1969, Report No. 91–875, February 1970. (Cat. No. 91/2:S. Rept. 975, $1.75)*

Developments in Aging, 1970, Report No. 92–46, March 1971. (Cat. No. 92/1:S. Rept. 46, $1.50)*

Developments in Aging: 1971 and January–March 1972, Report No. 92–784, April 1972. (Cat. No. 92/2:S. Rept. 784, $1.50).*

Developments in Aging, 1972 and January–March 1973, Report No. 93–147, May 1973. (Cat. No. 93/1:S. Rept. 147, $1.75).*

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 3, 1961.**

The 1961 White House Conference on Aging, basic policy statements and recommendations, May 15, 1961.**

New Population Facts on Older Americans, 1960, a staff report, May 24, 1961.**
Basic Facts on the Health and Economic Status of Older Americans, June 2, 1961.**
Health and Economic Conditions of the American Aged, a chart book, June 1961.**
State Action to Implement Medical Programs for the Aged, a staff report, June 8, 1961.**
A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.**
Mental Illness Among Older Americans, committee print, September 8, 1961.**
Comparison of Health Insurance Proposals for Older Persons, 1961–62, committee print, May 10, 1962.**
The Farmer and the President's Health Program, May 17, 1962.**
Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 24, 1962.**
Statistics on Older People, Some Current Facts About the Nation's Older People, June 14, 1962.**
Performance of the States, 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print report, June 15, 1962.**
Housing for the Elderly, committee print report, August 31, 1962.**
Some Current Facts About the Nation's Older People, October 2, 1962.**
A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, June 1963.**
Medical Assistance for the Aged, the Kerr-Mills Program, 1960–63, committee print report, October 1963.**
Blue Cross and Private Health Insurance Coverage of Older Americans, committee print report, July 1964.**
Increasing Employment Opportunities for the Elderly, committee print report, August 1964.**
Services for Senior Citizens, Report No. 1542, September 1964.**
Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1963–64, a staff report, October 1964.**
Frauds and Deceptions Affecting the Elderly—Investigations, Findings and Recommendations: 1964, committee print report, December 1964.**
Extending Private Pension Coverage, committee print report, June 1965.**
Health Insurance and Related Provisions of Public Law 89–97, the Social Security Amendments of 1965, committee print, October 1965.**
Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, a staff report, November 1965.**
The War on Poverty as It Affects the Elderly, Report No. 1287, January 1966.**
Services to the Elderly on Public Assistance, committee print report, March 1966.**

Needs for Services Revealed by Operation Medicare Alert, committee print report, October 1966.**
Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 31, 1966.**
Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print report, December 30, 1966.***
Reduction of Retirement Benefits Due to Social Security Increases, committee print report, August 21, 1967.***
Economics of Aging: Toward A Full Share in Abundance. A Working Paper, Committee Print, March 1969.** [1]
Homeownership Aspects of the Economics of Aging, A Working Paper, Fact Sheet, July 1969.** [1]
Health Aspects of the Economics of Aging. A Working Paper, Committee Print, July 1969 (Revised) (Cat. No. Y4:Ag4:H34/10, 25¢).* [1]
Social Security for the Aged: International Perspectives, A Working Paper, Committee Print, August 1969.** [1]
Older Americans in Rural Areas, A Working Paper, Fact Sheet, September, 1969.* [1]
Employment Aspects of the Economics of Aging, A Working Paper, Committee Print, December 1969 (Cat. No. Y4:Ag4:Em7/4, 15¢).** [1]
Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions, A Working Paper, Committee Print, January 1970.** [1]
The Stake of Today's Workers in Retirement Security: A Working Paper, Committee Print, April 1970.** [1]
Legal Problems Affecting Older Americans: A Working Paper, Committee Print, August 1970 [1] (Cat. No. Y4: Ag4: 0L1/2, 30¢).*
Income Tax Overpayments by the Elderly, Report No. 91–1464, December 1970 (Cat. No. 91/2:S. Rpt. 1464, 30¢).
Older Americans and Transportation: A Crisis in Mobility, Report No. 91–1520, December 1970 * (Cat. No. 91/2: S. Rpt. 1520, 50¢).
Economics of Aging: Toward A Full Share in Abundance, Report No. 91–1548, December 31, 1970 (Cat. No. 91/2:S. Rpt. 1548, $1.00).
Medicare, Medicaid Cutbacks in California: A Working Paper, Fact Sheet, May 10, 1971.* [1]
Mental Health Care and the Elderly: Shortcomings in Public Policy, Report No. 92–433, November, 1971. Y4. Ag 4: M52/2 (75¢).
The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States, Report No. 92–450, November 1971.*** Y4. Ag 4: H33 (35¢).
The Nation's Stake in the Employment of Middle-Aged and Older Persons (Working Paper), July 1971.* Y4. Ag4: Em 7/5 (35¢).
The Administration on Aging—or a Successor? (Committee Print Report) October 1971.* Y4. Ag4: Ag4/3 (30¢).
Alternatives to Nursing Home Care: A Proposal, October 1971.* Y4. Ag4: N93/3 (20¢).
Advisory Council on the Elderly American Indian (Working Paper), November 1971.***

[1] Working paper incorporated as an appendix to the hearing.

Elderly Cubans in Exile (Working Paper), November 1971. Y4. Ag4: C89 (20¢).

A Pre-White House Conference on Aging: Summary of Developments and Data (Committee Print Report), November 1971. 92–1: S. Rept. 505 (70¢).

Research and Training in Gerontology. A Working Paper, Committee Print, November 1971. Y4. Ag4: G31 (30¢).

Making Services for the Elderly Work: Some Lessons From the British Experience. Committee Print Report, November 1971. Y4. Ag4:Se 6/7 (15¢).

1971 White House Conference on Aging: A Report to the Delegates from the Conference Sections and Special Concerns Sessions, December 1971. 92–1:S. Doc. 53 (60¢).

Home Health Services in the United States. Committee Print Report, April 1972. Y4.Ag4:H34/11 (60¢) :*

Proposals to Eliminate Legal Barriers Affecting Elderly Mexican-Americans. A Working Paper, Committee Print, May 1972. Y4. Ag4:M57/2 (10¢).

Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees. Committee Print Report, May 1972.*** Y4.Ag4:C18/2 (25¢).

Action on Aging Legislation in 92d Congress. Committee Print, October 1972. Y4.Ag4:L52/3 (15¢).

Legislative History of the Older Americans Comprehensive Services Amendments of 1972 (Joint Committee Print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging), December 1972.**

The Rise and Threatened Fall of Service Programs for the Elderly: A report by the Subcommittee on Federal, State, and Community Services; Report No. 93–94, March 28, 1973. (Cat. No. 93/1, S. Rpt. 94, 60¢).

Housing for the Elderly, A Status Report. A Working Paper, Committee Print, April 1973. Y4.Ag4:H81/4 (25¢).

Older Americans Comprehensive Services Amendments of 1973, Committee Print, June 1973. Y4.Ag4:SE6/8 ($1.85).

Home Health Services in the United States: A Working Paper on Current Status, Committee Print, July 1973. Y4.Ag4:H34/13 (50¢).

Economics of Aging: Toward A Full Share in Abundance, Index to Hearings and Report. Committee Print, July 1973. Y4.Ag4:EC7/IND. (45¢).

Research on Aging Act, 1973: Report No. 93–299, Committee Print Report, July 1973. Y4.Ag4:R31/6 (25¢).

Post-White House Conference on Aging Reports, 1973 (Joint Committee Print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging), September 1973. Y4. L11/2:Ag4/7/973 ($5.20).

Improving the Age Discrimination Law. A Working Paper, Committee Print, September 1973. Y4.Ag4:Ag4/5 (50¢).

HEARINGS

Retirement Income of the Aging: **

Part 1. Washington, D.C., July 12–13, 1961.

Part 2. St. Petersburg, Fla., November 6, 1961.

Part 3. Port Charlotte, Fla., November 7, 1961.
Part 4. Sarasota, Fla., November 8, 1961.
Part 5. Springfield, Mass., November 29, 1961.
Part 6. St. Joseph, Mo., December 11, 1961.
Part 7. Hannibal, Mo., December 13, 1961.
Part 8. Cape Girardeau, Mo., December 15, 1961.
Part 9. Daytona Beach, Fla., February 14, 1962.
Part 10. Fort Lauderdale, Fla., February 15, 1962.

Problems of the Aging (Federal-State activities): **
Part 1. Washington, D.C., August 23–24, 1961.
Part 2. Trenton, N.J., October 23, 1961.
Part 3. Los Angeles, Calif., October 24, 1961.
Part 4. Las Vegas, Nev., October 25, 1961.
Part 5. Eugene, Oreg., November 8, 1961.
Part 6. Pocatello, Idaho, November 13, 1961.
Part 7. Boise, Idaho, November 15, 1961.
Part 8. Spokane, Wash., November 17, 1961.
Part 9. Honolulu, Hawaii, November 27, 1961.
Part 10. Lihue, Hawaii, November 29, 1961.
Part 11. Wailuku, Hawaii, November 30, 1961.
Part 12. Hilo, Hawaii, December 1, 1961.
Part 13. Kansas City, Mo., December 6, 1961.

Housing Problems of the Elderly: **
Part 1. Washington, D.C., August 22–23, 1961.
Part 2. Newark, N.J., October 16, 1961.
Part 3. Philadelphia, Pa., October 18, 1961.
Part 4. Scranton, Pa., November 14, 1961.
Part 5. St. Louis, Mo., December 8, 1961.

Nursing Homes: **
Part 1. Portland, Oreg., November 6, 1961.
Part 2. Walla Walla, Wash., November 10, 1961.
Part 3. Hartford, Conn., November 20, 1961.
Part 4. Boston, Mass., December 1, 1961.
Part 5. Minneapolis, Minn., December 4, 1961.
Part 6. Springfield, Mo., December 12, 1961.

Relocation of Elderly People: **
Part 1. Washington, D.C., October 22–23, 1962.
Part 2. Newark, N.J., October 26, 1962.
Part 3. Camden, N.J., October 29, 1962.
Part 4. Portland, Oreg., December 3, 1962.
Part 5. Los Angeles, Calif., December 5, 1962.
Part 6. San Francisco, Calif., December 7, 1962.

Frauds and Quackery Affecting the Older Citizen: **
Part 1. Washington, D.C., January 15, 1963.
Part 2. Washington, D.C., January 16, 1963.
Part 3. Washington, D.C., January 17, 1963.

Long-Term Institutional Care for the Aged (Federal programs): Washington, D.C., December 17–18, 1963.**

Housing Problems of the Elderly: **
Part 1. Washington, D.C., December 11, 1963.
Part 2. Los Angeles, Calif., January 9, 1964.
Part 3. San Francisco, Calif., January 11, 1964.

Increasing Employment Opportunities for the Elderly: **
Part 1. Washington, D.C., December 19, 1963.
Part 2. Los Angeles, Calif., January 10, 1964.
Part 3. San Francisco, Calif., January 13, 1964.
Services for Senior Citizens: **
Part 1. Washington, D.C., January 16, 1964.
Part 2. Boston, Mass., January 20, 1964.
Part 3. Providence, R.I., January 21, 1964.
Part 4. Saginaw, Mich., March 2, 1964.
Health Frauds and Quackery: **
Part 1. San Francisco, Calif., January 13, 1964.
Part 2. Washington, D.C., March 9, 1964.
Part 3. Washington, D.C., March 10, 1964.
Part 4A. Washington, D.C., April 6, 1964 (eye care).
Part 4B. Washington, D.C. April 6, 1964 (eye care).
Blue Cross and other private health insurance for the Elderly: **
Part 1. Washington, D.C., April 27, 1964.
Part 2. Washington, D.C., April 28, 1964.
Part 3. Washington, D.C., April 29, 1964.
Part 4A. Appendix.
Part 4B. Appendix.
Deceptive or Misleading Methods in Health Insurance Sales: Washington, D.C., May 4, 1964.**
Nursing Homes and Related Long-Term Care Services: **
Part 1. Washington, D.C., May 5, 1964.
Part 2. Washington, D.C., May 6, 1964.
Part 3. Washington, D.C., May 7, 1964.
Interstate Mail Order Land Sales: **
Part 1. Washington, D.C., May 18, 1964.
Part 2. Washington, D.C., May 19, 1964.
Part 3. Washington, D.C., May 20, 1964.
Preneed Burial Service: Washington, D.C., May 19, 1964.**
Conditions and Problems in the Nation's Nursing Homes:**
Part 1. Indianapolis, Ind., February 11, 1965.
Part 2. Cleveland, Ohio, February 15, 1965.
Part 3. Los Angeles, Calif., February 17, 1965.
Part 4. Denver, Colo., February 23, 1965.
Part 5. New York, N.Y., August 2–3, 1965.
Part 6. Boston, Mass., August 9, 1965.
Part 7. Portland, Maine, August 13, 1965.
Extending Private Pension Coverage:**
Part 1. Washington, D.C., March 4, 1965.
Part 2. Washington, D.C., March 5 and 10, 1965.
Services to the Elderly on Public Assistance:**
Part 1. Washington, D.C., August 18–19, 1965.
Part 2. Appendix.
The War on Poverty as it Affects Older Americans:**
Part 1. Washington, D.C., June 16–17, 1965.
Part 2. Newark, N.J., July 10, 1965.
Part 3. Washington, D.C., January 19–20, 1966.
Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques: Washington, D.C., September 20, 21, and 22, 1966.**

Consumer Interests of the Elderly:***
Part 1. Washington, D.C., January 17–18, 1967.
Part 2. Tampa, Fla., February 2–3, 1967.
Tax Consequences of Contributions to Needy Older Relatives: Washington, D.C., June 15, 1966.***
Needs for Services Revealed by Operation Medicare Alert: Washington, D.C., June 2, 1966.**
Costs and Delivery of Health Services to Older Americans:**
Part 1. Washington, D.C., June 22–23, 1967.
Part 2. New York, N.Y., October 19, 1967.
Part 3. Los Angeles, Calif., October 16, 1968.
Retirement and the Individual:***
Part 1. Washington, D.C., June 7–8, 1967.
Part 2. Ann Arbor, Mich., July 26, 1967.
Reduction of Retirement Benefits Due to Social Security Increases: Washington, D.C., April 24–25, 1967.**
Rent Supplement Assistance to the Elderly: Washington, D.C., July 11, 1967.**
Long-Range Program and Research Needs in Aging and Related Fields: Washington, D.C., December 5–6, 1967.**
Hearing Loss, Hearing Aids, and the Elderly: Washington, D.C., July 18 and 19, 1968.**
Adequacy of Services for Older Workers: Washington, D.C., July 24, 25, and 29, 1968.**
Usefulness of the Model Cities Program to the Elderly:**
Part 1. Washington, D.C., July 23, 1968.
Part 2. Seattle, Wash., October 14, 1968.
Part 3. Ogden, Utah, October 24, 1968.
Part 4. Syracuse, N.Y., December 9, 1968.
Part 5. Atlanta, Ga., December 11, 1968.
Part 6. Boston, Mass., July 11, 1969.
Part 7. Washington, D.C., October 14–15, 1969.
Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans:**
Part 1. Los Angeles, Calif., December 17, 1968.
Part 2. El Paso, Tex., December 18, 1968.
Part 3. San Antonio, Tex., December 19, 1968.
Part 4. Washington, D.C., January 14–15, 1969.
Part 5. Washington, D.C., November 20–21, 1969.
Economics of Aging: Toward a Full Share in Abundance: (Y4:Ag4:Ec7/Pts.):
Part 1. Washington, D.C., April 29 and 30, 1969—$1.25.***
Part 2. Ann Arbor, Mich., Consumer Aspects, June 9, 1969—60¢.***
Part 3. Washington, D.C., Health Aspects, July 17 and 18, 1969—$1.00.*
Part 4. Washington, D.C., Homeownership Aspects, July 31 and August 1, 1969—55¢.**
Part 5. Paramus, N.J., Central Suburban Area, August 14, 1969—40¢.***
Part 6. Cape May, N.J., Retirement Community, August 15, 1969—30¢.

Part 7. Washington, D.C., International Aspects, August 25, 1969—30¢.
Part 8. Washington, D.C., National Organizations, October 29, 1969—30¢.
Part 9. Washington, D.C., Employment Aspects, December 18 and 19, 1969—$1.00.**
Part 10A. Washington, D.C., Pension Aspects, February 17, 1970—60¢.
Part 10B. Washington, D.C., Pension Aspects, February 18, 1970—70¢.
Part 11. Washington, D.C., Concluding Hearing, May 4, 5, and 6, 1970—$1.00.

The Federal Role in Encouraging Preretirement Counseling and New Work Lifetime Patterns: Washington, D.C., July 25, 1969.**

Trends in Long-Term Care: (Cat. No. Y4:Ag4:C18/Pts.)
Part 1. Washington, D.C., July 30, 1969—60¢.***
Part 2. St. Petersburg, Fla., January 9, 1970—50¢.***
Part 3. Hartford, Conn., January 15, 1970—40¢.
Part 4. Washington, D.C., Marietta, Ohio fire, February 9, 1970—40¢.***
Part 5. Washington, D.C., Marietta, Ohio fire, February 10, 1970—25¢.
Part 6. San Francisco, California, February 12, 1970—30¢.***
Part 7. Salt Lake City, Utah, February 13, 1970—30¢.
Part 8. Washington, D.C., May 7, 1970—50¢.
Part 9. Washington, D.C., August 13, 1970 (Salmonella)—30¢.
Part 10. Washington, D.C., December 14, 1970 (Salmonella)—50¢.
Part 11. Washington, D.C., December 17, 1970—50¢.
Part 12. Chicago, Ill., April 2, 1971—($1.00).
Part 13. Chicago, Ill., April 3, 1971—(65¢).
Part 14. Washington, D.C., June 15, 1971—(25¢).
Part 15. Chicago, Ill., September 14, 1971—(75¢).
Part 16. Washington, D.C., September 29, 1971—(55¢).
Part 17. Washington, D.C., October 14, 1971—($1.85).
Part 18. Washington, D.C., October 28, 1971—(45¢).
Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971—(60¢).
Part 19B. Minneapolis-St. Paul, Minn., November 29, 1971—($1.00).
Part 20. Washington, D.C., August 10, 1972—(70¢).
Part 21. Washington, D.C., October 10, 1973.[2]
Part 22. Washington, D.C., October 11, 1973.[2]

Older Americans in Rural Areas: (Cat. No. Y4:Ag4:R88/Pts.)
Part 1. Des Moines, Iowa, September 8, 1969—55¢.
Part 2. Majestic-Freeburn, Ky., September 12, 1969—15¢.
Part 3. Fleming, Ky., September 12, 1969—30¢.
Part 4. New Albany, Ind., September 16, 1969—40¢.
Part 5. Greenwood, Miss., October 9, 1969—30¢.
Part 6. Little Rock, Ark., October 10, 1969—35¢.
Part 7. Emmett, Idaho, February 24, 1970—20¢.
Part 8. Boise, Idaho, February 24, 1970—30¢.

[2] Price not determined at time of this printing.

Part 9. Washington, D.C., May 26, 1970—30¢.
Part 10. Washington, D.C., June 2, 1970—25¢.
Part 11. Dogbone-Charleston, W. Va., October 27, 1970—40¢.
Part 12. Wallace-Clarksburg, W. Va., October 28, 1970—25¢.

Sources of Community Support for Federal Programs Serving Older Americans: (Cat. No. Y4Ag4:C73.)
Part 1. Ocean Grove, N.J., April 18, 1970—50¢.
Part 2. Washington, D.C., June 8–9, 1970—70¢.

Income Tax Overpayments by the Elderly, Washington, D.C., April 15, 1970—40¢.

Legal Problems Affecting Older Americans: (Cat. No. Y4:Ag4:L52/2 Pts).
St. Louis, Mo., August 11, 1970—50¢.
Boston, Mass., April 30, 1971—25¢.

Evaluation of Administration on Aging and Conduct of White House Conference on Aging: (Cat. No. Y4:Ag4:Ag4/2/Pts).
Part 1. Washington, D.C., March 25, 1971 (50¢).
Part 2. Washington, D.C., March 29, 1971 (25¢).
Part 3. Washington, D.C., March 30, 1971 (30¢).
Part 4. Washington, D.C., March 31, 1971 (30¢).
Part 5. Washington, D.C., April 27, 1971 (30¢).
Part 6. Orlando, Fla., May 10, 1971 (30¢).
Part 7. Des Moines, Iowa, May 13, 1971 (35¢).
Part 8. Boise, Idaho, May 28, 1971 (30¢).
Part 9. Casper, Wyo., August 13, 1971 (25¢).
Part 10. Washington, D.C., February 3, 1972 (25¢).

Cutbacks in Medicare and Medicaid Coverage (Cat. No. Y4:Ag4:M46/4/Pts).
Part 1. Los Angeles, Calif., May 10, 1971 [1] (60¢).
Part 2. Woonsocket, R.I., June 14, 1971 (30¢).
Part 3. Providence, R.I., September 20, 1971.**

Unemployment Among Older Workers (Cat. No. Y4:Ag4:UN 2/Pts).
Part 1. South Bend, Ind., June 4, 1971 (30¢).
Part 2. Roanoke, Ala., August 10, 1971 (30¢).
Part 3. Miami, Fla., August 11, 1971 (30¢).
Part 4. Pocatello, Idaho, August 27, 1971 (40¢).

Adequacy of Federal Response to Housing Needs of Older Americans: (Cat. No. Y4:Ag4:H81/3 Pts).
Part 1. Washington, D.C., August 2, 1971 (30¢).
Part 2. Washington, D.C., August 3, 1971 (20¢).
Part 3. Washington, D.C., August 4, 1971 (55¢).
Part 4. Washington, D.C., October 28, 1971 (30¢).
Part 5. Washington, D.C., October 29, 1971 (20¢).
Part 6. Washington, D.C., July 31, 1972 (45¢).
Part 7. Washington, D.C., August 1, 1972 (45¢).
Part 8. Washington, D.C., August 2, 1972 (45¢).
Part 9. Boston, Mass., October 2, 1972 (45¢).

A Barrier-Free Environment for the Elderly and the Handicapped: (Cat. No. Y4:Ag4:EN8/Pts).
Part 1. Washington, D.C., October 18, 1971—30¢.
Part 2. Washington, D.C., October 19, 1971—30¢.
Part 3. Washington, D.C., October 20, 1971—30¢.

[1] Working paper incorporated into appendix of hearing.

Flammable Fabrics and Other Fire Hazards to Older Americans: Washington, D.C., October 12, 1971 (Cat. No. Y4:Ag4:F61/Pts.) 40¢.

Death With Dignity: An Inquiry Into Related Public Issues. (Cat. No. Y4:Ag4:D34/Pts.)
- Part 1. Washington, D.C., August 7, 1972 (30¢).
- Part 2. Washington, D.C., August 8, 1972 (45¢).
- Part 3. Washington, D.C., August 9, 1972 (45¢).

Future Directions in Social Security. (Cat. No. Y4. Ag4:So1/2/Pts.)
- Part 1. Washington, D.C., January 15, 1973 (65¢).
- Part 2. Washington, D.C., January 22, 1973 (50¢).
- Part 3. Washington, D.C., January 23, 1973 (50¢).
- Part 4. Washington, D.C., July 25, 1973 (50¢).
- Part 5. Washington, D.C., July 26, 1973 (50¢).

Fire Safety in Highrise Buildings for the Elderly. (Cat. No. Y4. Ag4: F51/Pts.)
- Part 1. Washington, D.C., February 27, 1973 (50¢).
- Part 2. Washington, D.C., February 28, 1973 (50¢).

Barriers to Health Care for Older Americans. (Cat. No. Y4. Ag4: H34/14/Pts.)
- Part 1. Washington, D.C., March 5, 1973 (75¢).
- Part 2. Washington, D.C., March 6, 1973 (70¢).
- Part 3. Livermore Falls, Maine, April 23, 1973 (75¢).
- Part 4. Springfield, Ill., May 16, 1973 (80¢).
- Part 5. Washington, D.C., July 11, 1973 ($1.30).
- Part 6. Washington, D.C., July 12, 1973 (70¢).
- Part 7. Coeur d'Alene, Idaho, August 4, 1973 (70¢).

Training Needs in Gerontology. (Cat. No. Y4. Ag4: G-31/2/Pts.)
- Part 1. Washington D.C., June 19, 1973 (90¢).
- Part 2. Washington, D.C., June 21, 1973 (70¢).

Hearing Aids and the Older American. (Cat. No. Y4. Ag4: H35/Pts.)
- Part 1. Washington, D.C., September 10, 1973.[2]
- Part 2. Washington, D.C., September 11, 1973.[2]

OTHER DOCUMENTS AVAILABLE

Hearings before the Special Subcommittee on Aging of the U.S. Senate Committee on Labor and Public Welfare, available from the Special Committee on Aging are:

"Amend the Older Americans Act of 1965—S. 2877 and S. 3326", May 24, 25, and June 15, 1966.**

"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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