88TH CONGRESS
1st Session

SENATE

REPORT
No. 8

DEVELOPMENTS IN AGING
1959 TO 1963

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

TOGETHER WITH

SUPPLEMENTAL AND MINORITY VIEWS

PURSUANT TO

S. RES. 33, FEBRUARY 13, 1961

AND

S. RES. 238, FEBRUARY 7, 1962

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

FEBRUARY 11, 1963.—Ordered to be printed

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NOTE.—Senator Smith was a member of the committee until November 6, 1962; Senator Long of Hawaii and Senator Bush ceased to be members January 2, 1963.

LETTER OF TRANSMITTAL

U.S. SENATE,
February 8, 1963.

Hon. LYNDON B. JOHNSON,
President, U.S. Senate.

DEAR MR. PRESIDENT: I have the honor of submitting to you the report of the Special Committee on Aging in accordance with Senate Resolution 33, adopted February 13, 1961, as amended by Senate Resolution 238, adopted February 7, 1962.

This report documents the activities and accomplishments of the committee and, in addition, reviews recent developments in this increasingly important area of national concern which deals with the problems of the aged and aging.

We believe that the achievements of the committee, as set forth in this report, confirm the wisdom of the Senate in establishing the special committee 2 years ago. One happy result in which the committee has played a significant part has been a sharpened focus and an increased public awareness of the problems facing the Nation's more than 17 million senior citizens.

A resolution to extend the activities of the committee for 1 year has been introduced and it is my hope that it will be approved.

On behalf of the other members of the committee and the committee staff, I should like to take this opportunity to express to you and to the other officers of the Senate our appreciation for the helpfulness and cooperation that have been so unfailingly extended to us.

Sincerely,

PAT MCNAMARA,
Chairman, Special Committee on Aging.

SENATE RESOLUTION 33, 87TH CONGRESS, 1ST SESSION

Whereas our great and satisfying success in making possible a longer life for a large and increasing percentage of our people has produced, and will continue to produce, new and serious strains in the fabric of our social and economic life; and

Whereas, since the sixteen millions of people sixty-five years of age and older in the United States will have increased to twenty million by 1975, it is incumbent upon us now to attempt to discover what social and economic conditions will enable our older citizens to contribute to our productivity and to lead meaningful, satisfying, independent lives; and

Whereas the Subcommittee on Problems of the Aged and Aging of the Committee on Labor and Public Welfare has amassed a wealth of information on the subject which is unmatched anywhere, which should be kept current and mined for possible answers to particular facets of the problem; and

Whereas that subcommittee has shown that although specific elements of the problem may call for action by various legislative committees, the problems themselves are highly interrelated, require coordinated review and call for recommendations based on studies in depth of the total problem; and

Whereas that subcommittee has concluded that this subject is of such grave concern to the Nation as to require the full time and attention of a special committee of the Senate: Now, therefore, be it

Resolved, That there is hereby created a special committee to be known as the Special Committee on Aging and to consist of nine Senators to be appointed by the President of the Senate as soon as practicable after the date of adoption of this resolution. Six members of the committee shall be appointed from the majority party and three members from the minority party.

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

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

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

SEC. 5. For purposes of this resolution, the committee is authorized to employ on a temporary basis through January 31, 1962, such technical, clerical, or other assistants, experts, and consultants: *Provided*, That the minority is authorized to select one person for appointment, and the person so selected shall be appointed and his compensation shall be so fixed that his gross rate shall not be less by more than $1,400 than the highest gross rate paid to any other employee; and, with the prior consent of the executive department or agency concerned and the Committee on Rules and Administration, employ on a reimbursable basis such executive branch personnel, as it deems advisable.

SEC. 6. The expenses of the committee, which shall not exceed $150,000, shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee.

SEC. 7. The committee shall report the results of its study and investigation, together with such recommendations as it may deem advisable, to the Senate at the earliest practicable date, but not later than January 31, 1962. The committee shall cease to exist at the close of business on January 31, 1962.

SENATE RESOLUTION 238, 87TH CONGRESS, 2D SESSION

Resolved, That the time for filing a final report by the Special Committee on Aging, established by S. Res. 33, Eighty-seventh Congress, agreed to February 13, 1961, as amended and supplemented, is hereby extended to January 31, 1963.

SEC. 2. For the purpose of enabling the special committee to complete its work and prepare such final report, it is hereby authorized to exercise, until such date, all of the duties, functions, and powers conferred upon it by S. Res. 33, Eighty-seventh Congress, as amended and supplemented.

SEC. 3. The expenses of the special committee under this resolution, which shall not exceed $185,000 from February 1, 1962, through January 31, 1963, shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the special committee.

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INTRODUCTION

The senior citizens of the United States constitute the second fastest growing age group in our population, exceeded only by children aged 5 to 14.

Today these senior citizens number more than 17 million. Each day their numbers experience a net increase of 1,000. By 1970 they will total 20 million.

Today the "very old" age group—those 85 and over—exceed 900,000, an increase of 920 percent since 1920.

These sparse statistics dramatize the phenomenal increase in longevity that is taking place in this country in the second half of the 20th century. Both the Congress and the public are paying increased attention to this pronounced demographic shift. It is inevitable that this concern with the problems of our older citizens will occupy a much larger share of our attention and efforts in the years to come.

While all levels of government have a legitimate and important function in this area, many problems of the aging—such as health—are national problems and require national solutions. This means a continued and growing involvement of the Congress in an area of national responsibility that has become generally accepted during the past several years.

The problems of the older people of this country have been the subject of special Senate scrutiny since 1959, when the Subcommittee on Problems of the Aged and Aging was established as a unit of the Labor and Public Welfare Committee.[1]

In February 1961, the Special Senate Committee on Aging was created as a successor unit, under the chairmanship of Senator Pat McNamara, of Michigan, who also had served as chairman of the old subcommittee. This special committee attracted 21 members, making it the second largest committee in the Senate.

This document is a report on the activities, the achievements, and the accomplishments of the Senate Special Committee on Aging during the past 2 years, and a review of developments in the aging field since 1959.

This report reviews, among other things, the legislation proposed and passed to deal with the problems of the aging. It is interesting to note that seven laws have been passed since 1959 that deal primarily with the problems of the elderly. In addition, the report reviews pertinent sections of other legislation. In this connection, it is important to emphasize that the functions of the Special Committee on Aging are limited to investigation, factfinding, and education. This is not a legislative committee, and as such does not hold hearings on or report out bills.

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[1] Members of the subcommittee were: Senators Pat McNamara, of Michigan, chairman; John F. Kennedy, Massachusetts; Joseph S. Clark, Pennsylvania; Jennings Randolph, West Virginia; Everett McKinley Dirksen, Illinois, and Barry Goldwater, Arizona.

One important function discharged by the special committee, with its specialized purpose and expert staff, has been to assemble and interpret a vast amount of information on problems relating to the elderly. The committee, for example, has been responsible for 24 publications (listed in the appendix), that have thrown much valuable light on such highly debated issues as medical care.[2]

The committee believes, on the basis of the past 2 years' experience, that its work should be continued and expanded. Although there has been some progress, the problems facing the elderly have become more acute with the passage of time. Congressional concern in this area must and shall continue, either through a limited extension of the committee's existence or creation of a permanent committee.

The first—and longest—chapter of this report deals with the health status of the elderly.

Three years ago, the predecessor of this committee stated in its first annual report to the Senate:

> The No. 1 problem of America's senior citizens is how to meet the costs of health care at a time when income is lowest and potential or actual disability at its highest. Its solution should have top priority for legislative consideration in 1960.

We are obliged to report today that this problem is even more acute and its solution even more imperative. This has been underlined by the passage of 3 years' time which have seen the costs of hospital and related care mount higher and higher and even further beyond the limited financial resources of older Americans.

We repeat that the solution of this problem—despite intervening legislation—remains a matter of great national urgency and demands top legislative priority.

Perhaps one of the most important methods through which the committee has gained the information it sought was through an extensive series of hearings to supplement staff research.

Soon after its formation, the special committee held hearings in Washington, D.C., to explore four subject areas: Retirement income, housing, Federal-State activities in the field of aging, and nursing homes.

But the committee, recognizing that the overwhelming majority of America's senior citizens had neither the resources to come to Washington in person to testify, nor the means to send skilled lobbyists in their behalf, decided to go to the people and hold hearings in different parts of the country.

A factor in this decision was the desire to give special attention to the problems of older people living in rural areas. It comes as a surprise to many to discover that more than 5.3 million aged persons, nearly one-third of the total, live on farms or in small towns of less than 2,500 population.

Consequently, ad hoc subcommittees of the Special Committee on Aging conducted hearings in 36 communities throughout the country,

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[2] A complete list of publications by both the subcommittee and the special committee appear in appendix A to this report.

resulting in the most comprehensive congressional study of aging problems ever attempted. More than 1,000 persons actively participated in these grassroots hearings.

About half of these were expert witnesses who presented testimony on the four subjects investigated during the morning sessions: Nursing homes, retirement income, housing for the elderly, and Federal-State relationships in the field of aging.

The other witnesses—the older people whom we consider to be the "real experts"—participated actively in the town-meeting-type discussions held in the afternoons or evenings by the subcommittees.

This personal testimony was supplemented by hundreds of letters sent to the committee at its request by senior citizens who were unable to attend public hearings.

Late in 1962 a subcommittee held a series of hearings on the involuntary relocation of older people as a result of such public projects as highway construction and urban renewal.

In mid-January 1963 the committee held 3 days of hearings that focused considerable public attention on frauds, quackery, and other ways in which our older people are being exploited.

It is those hearings—and the staff research to which they led—that provide the base for the reports we have issued and the recommendations we make herein.

88TH CONGRESS
1st Session

SENATE

REPORT
No. 8

DEVELOPMENTS IN AGING 1959 TO 1963

FEBRUARY 11, 1963.—Ordered to be printed

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

REPORT

Together with

MINORITY AND SUPPLEMENTAL VIEWS

CHAPTER I—DEVELOPMENTS IN HEALTH

The Health Status of the Elderly and the Financing of Adequate Health Services

Three years ago, the predecessor of this committee stated in its report to the Senate that:

> The No. 1 problem of America's senior citizens is how to meet the costs of health care at a time when income is lowest and potential or actual disability at its highest. Its solution should have top priority for legislative consideration in 1960.

The 3 years that have passed since that recommendation was made have served to underline the statement. The costs of hospital and related care have mounted higher and higher and ever further beyond the limited financial resources of older Americans. Today, the problem is even more acute and its solution even more imperative. Today, the attainment of an honorable, equitable, and effective solution lies within the realm of achievement. It is vital that we act to effectuate this solution in 1963.

We are well aware that the elderly are not a homogeneous, undifferentiated segment of the population. But, older Americans do, in general, experience certain problems in common—problems not necessarily encountered in kind or extent by the younger population. With regard to health status and the financing of health services, the elderly do suffer common and pervasive problems which vary, at most, only in degree.

The question of adequate financing of the health expenses of older Americans may be said to have been characterized by four major developments during the years 1959 through 1962:

(1) The development, dissemination, and discussion of a vast body of data and testimony attesting to the dimensions of the problem.

(2) Eleventh-hour attempts by private health insurers to cope with what is, in terms of their underwriting philosophy, the insoluble problem of providing adequate benefits at acceptable premiums for a high-risk, low-income segment of the population.

(3) The passage in late summer of 1960 of the Kerr-Mills Act which attempted to solve the problem by means of the creation of a new category of persons eligible for public assistance—the medically indigent aged.

(4) Evolution of legislative proposals which would afford a "floor of protection" for hospital and related expenses and which would, basically, be financed through the social security mechanism.

I. The Development, Dissemination and Discussion of a Vast Body of Data and Testimony Attesting to the Dimensions of the Problem

During the period 1959 through 1962, the fruits of an enormous amount of research into the health status and needs of the elderly were offered for consumption and digestion. In instances, some of the fruit was slightly rotten, as in the case, for example, of a supposedly objective, scientific, academic study, the ill-famed Wiggins-Schoeck survey, which appeared in reputable disguise but which, fortunately, was quickly unmasked and revealed as pseudoscientific half-effort.[1] This was among the first of a series of nonobjective studies or misrepresentations of valid studies which pretended to demonstrate that the preponderance of America's elderly have no financial problem as regards paying for medical care.

Findings and conclusions were presented and discussed in a variety of forums and fashions, both popular and professional, and in manners ranging from sober to sensational. They were discussed in congressional hearing rooms and in the confines of the physician's office. They were magnified, diminished, distorted, and discarded to suit a variety of intents and purposes. The facts were also properly employed, and they were also inescapable.

The wealth of data assembled in preparation for the White House Conference on Aging in January 1961 provided clear-cut evidence that aged people—as a group—have incomes too low to finance their heavy medical costs. The nature and dimensions of the problem were conclusively defined in the carefully documented background papers prepared under the direction of national planning committees and in the factual reports developed by each State (subsequently published by the Subcommittee on Problems of the Aging and Aged).[2] For those who might still doubt that a problem existed, there was further telling evidence in the lengthy document—referred to as "exhaustive research into the economic and social situation of the aged"—which was prepared and used by Blue Cross and the American Hospital Association in arriving at the decision that governmental financial assistance would be needed to effectively implement their initial proposal for a national Blue Cross program for the aged. The hundreds of pages of expert testimony, illustrated by heartfelt statements from older people, which were collected during the course of our committee hearings are another source of irrefutable evidence.

But the "battle of the income statistics"—always at its hottest when directed to the problem of financing of health costs—is not yet over. As recently as October 1962, the AMA was still contending that "the aged as a group are substantially better off on the average than younger Americans."[2a] This contention is based solely on misinter-

[1] This was a glowing report released in 1960, on the health status of the elderly which was widely publicized and promoted by the American Medical Association. The report, based upon a survey of some older persons, was prepared by Profs. J. W. Wiggins and Helmut Schoeck, of Emory University. The report's errors—both in technique and conclusions—were so glaring that it was immediately repudiated, in letters to the Subcommittee on Problems of the Aged and the Aging, by the majority of the sociologists who had supervised the interviewing. These men had not been afforded an opportunity to assist in drafting the questionnaire employed, determine the population sample, nor participate in evaluation of the findings.

[2] Background studies prepared by State committees for the White House Conference on Aging, 86th Cong., 2d sess., 14 volumes.

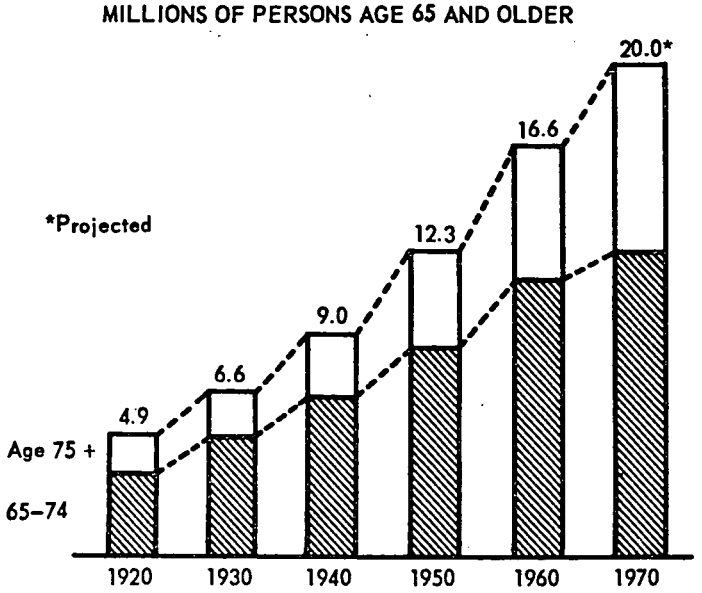
[2a] Dr. George M. Fister, American Medical Association press release, Chicago, Oct. 15, 1962.

pretations of perfectly valid data from the U.S. Census Bureau and the University of Michigan's survey of consumer finances, not on any newly available data. (See Appendix D: "Low Incomes of the Aged: An Actual Fact or a Statistical Myth?" and Appendix E: "University of Michigan news service release of Oct. 24, 1962.)

The section which follows presents some of the unvarnished facts and findings developed by responsible sources.[3] They prove, beyond any possible doubt, that a positive program of hospital and related benefits is absolutely essential to the maintenance of both the health and financial well-being of older Americans.

The data included in the following section are precisely that—averages, ranges, and so forth. While these are useful evaluative tools, they are also impersonal devices. They cannot describe the depth of individual bewilderment and inability to cope with health-related problems which thousands of older Americans have depicted so vividly at the many hearings held during the past 4 years by this committee and the former Subcommittee on Problems of the Aged and Aging.

(A) By 1970 some 20 million Americans will be age 65 or over. The highest proportionate increases among the elderly have been and will continue to be in the oldest age bracket—the 75-and-over group.



(B) Illness and injury have far greater impact upon the 65-and-over segment of the population than upon the younger population. The greatest impacts fall upon those in the oldest age brackets of the 65-and-over group. Life has been prolonged—but each year of prolongation is accompanied, on the average, by a decline in health and

[3] Portions of this section are derived and in part excerpted from "The Older Population," which appeared in the Department of Health, Education, and Welfare's publication, Health, Education, and Welfare Indicators for November 1962. The article was based upon data previously published by the Social Security Administration, Public Health Service, Bureau of the Census, and Housing and Home Finance Agency. Similarly, other material is derived and excerpted from "The Health Care of the Aged," a study published by the Department of Health, Education, and Welfare in mid-1962.

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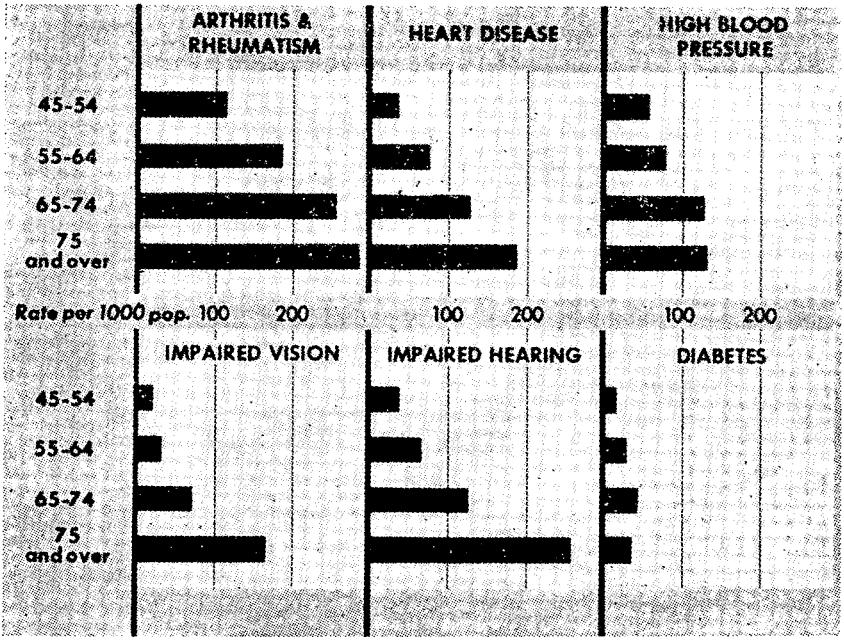
physical capacity. The elderly have a far greater incidence of chronic and mental illness than does the younger population. They continue to be plagued by acute illness. They are highly susceptible to accidental injury.

(1) The national health survey [4] reveals that four out of every five persons aged 65 and over have one or more chronic conditions in contrast to only two out of five in the younger ages. As the accompanying chart indicates, the incidence of chronic illness increases in the older age groups—precisely those age brackets which are experiencing the greatest relative increases in numbers.

Most Common Causes of Illness and Impairment Among Older People



(2) The incidence of acute illnesses, particularly respiratory conditions, is significant among the elderly. In 1959, according to the national health survey, there was a total of 134 acute conditions reported for every 100 individuals aged 65 and over. Such illnesses are frequently the immediate cause of death for elderly persons with chronic conditions.

(3) Accidents are a frequent cause of disability among the elderly. Approximately one of every four older Americans was injured in 1959, with most of these accidents occurring in the home.

[4] All of the national health survey data cited were derived from household interviews. It excludes persons in homes for the aged, nursing homes, long-stay hospitals, as well as those persons whose illness resulted in death during the survey year. For these reasons, the data present a more favorable picture of the health situation of the elderly than is actually the case.

(4) Mental illness is a major health problem of the elderly. About one of every four persons initially admitted to public hospitals for the mentally ill is 65 or over. The first admission rate among the population aged 65 or over is more than 2½ times that of the younger population.

(C) The consequences of the comparatively poorer health of the elderly in relation to the younger population are a greater degree of disability for longer periods of time coupled with markedly higher utilization of medical services.

(1) As with the progressive increase in the incidence of illness and injury in the older age brackets, the extent of disability due to chronic illness increases with age. Substantially more than one-half of the older persons with one or more chronic conditions have some limitation of activity. Among younger persons with chronic illness, only one in five suffers any limitation of activity.

Another gauge of the effects of chronic illness upon the elderly is the number of days of restricted activity and bed disability. In 1960, according to the national health survey, the aged were restricted in their usual activities an average of 38 days per year—more than 2½ times as many days as younger persons. On 14 of these days, the aged person was confined to bed all or most of the time.

(2) The elderly are great consumers of personal and institutional medical services by comparison with the lesser needs of the younger population. Older Americans use a greater volume of physicians' services and are admitted to hospitals more often and for longer periods of time. They are the principal users of nursing home and other long-term care facilities. They receive a greater amount of home care. They need and use more drugs.

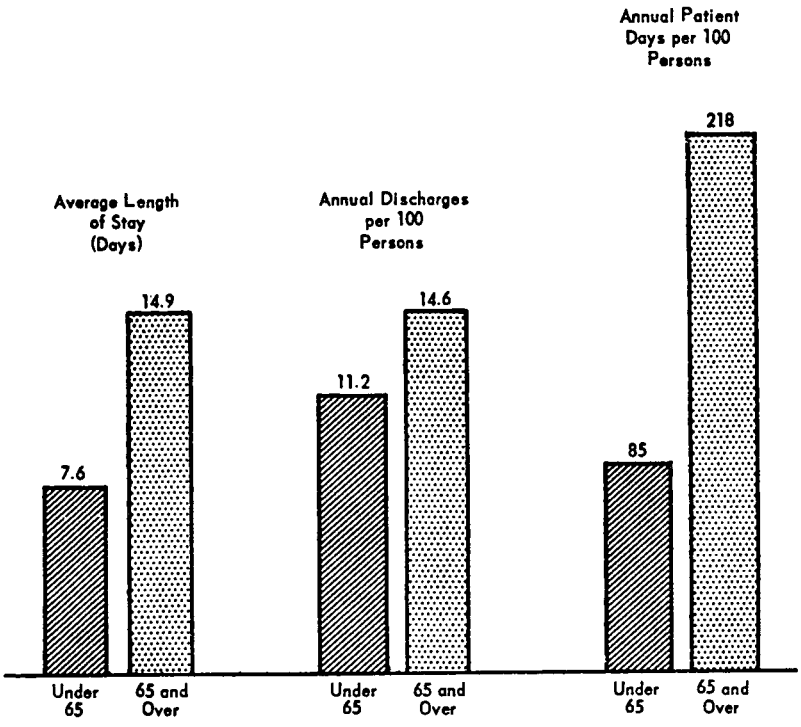
(*a*) Persons aged 65 and over averaged 6.8 physician visits per year in 1959—two more than younger persons. Those with limitation of activity due to chronic illness consult a physician more often than those without such conditions, and the number of physician visits increases with the severity of the condition. However, among persons with equally severe limitations, persons with higher incomes are seen by a doctor more often than those with lower incomes.

(*b*) The elderly are found at the top of every conventional index by which hospital utilization is measured—hospital admissions or discharges, length of stay, days of care, and number of persons hospitalized per given population. Data from the national health survey for the 2-year period ending June 1960 show that discharges from short-stay hospitals averaged 14.6 per 100 persons aged 65 and over as compared with 11.2 discharges per 100 persons under age 65. Older persons spent, on the average, about 2½ times as many days in the hospital as did individuals under 65—218 days as compared with 85 days per 100 persons. The average length of stay of the elderly confined in short-term hospitals was about twice as long as for younger persons—14.9 days as compared with 7.6 days.

The accompanying chart illustrates hospital utilization data by age grouping. It should be noted again that since the health survey data exclude persons who died in the hospital, or subsequently, during the year before the interview, there is a substantial understatement of hospital utilization by the elderly. A survey based upon hospital records indicates that the inclusion of hospitalization received by

persons who died during the survey year would result in increases of one-fourth to one-third in the total volume of hospitalization for persons 65 and over.[5]

UTILIZATION RATES IN SHORT-TERM GENERAL HOSPITALS*



*Based on household interviews of persons living at the time of interview.
SOURCE: Public Health Service, U.S. National Health Survey, *1958–60*

(*c*) The Social Security Administration estimates that 85 to 95 percent of nursing home beds are occupied by persons aged 65 and over. It further estimates that nursing homes provide between 480 and 580 days of care annually per 100 older Americans. The American Hospital Association estimates that the elderly comprise one-third of the patient population in mental hospitals, one-fifth of those in tuberculosis hospitals, and some one-half of the patients in the remaining long-term hospitals. The association concluded that these facilities provide 450 days of care annually per 100 elderly persons. Thus, it is estimated that all long-term institutions provide between 930 and 1,030 days of care annually, per 100 elderly individuals.

(*d*) Persons 65 and over receive 15 times as much personal care in the home as does the younger population, according to data from the national health survey. Such care includes constant or part-time help or nursing care for eating, dressing, or toilet activities. The

[5] "Hospitalization in the Last Year of Life," Public Health Service Publication No. 584–D3, June 1961.

amount of such care at home increases substantially with age. As the following table indicates, persons 75 and over use 4 times the amount of such services as do individuals 65 to 74 years of age.

Persons receiving care at home: Rates per 1,000 population by age and type of care, July 1958 to June 1959

[Noninstitutional population of the United States]

Age	Rates per 1,000 population		
	Total	Constant	Part time
65 and over, total	44.3	24.8	19.5
Under 65, total	3.0	1.8	1.2
75 and over	87.7	52.7	35.0
65 to 74	21.9	10.4	11.5
55 to 64	9.6	5.9	3.7
45 to 54	4.0	2.2	1.8
Under 45	2.0	1.2	.8

Source: Public Health Service, U.S. National Health Survey, "Persons Receiving Care at Home, United States, July 1958–June 1959" (Publication No. 584–B28), October 1961.

(*e*) As has been noted, four of every five older Americans suffer from one or more chronic illnesses. Many of these people are in need of one or more drugs on a continuing basis. According to the Health Information Foundation, a research organization financed by the pharmaceutical industry, the average annual expenditures of the elderly for both prescribed and nonprescribed medicines are more than double that of the average for the entire population.

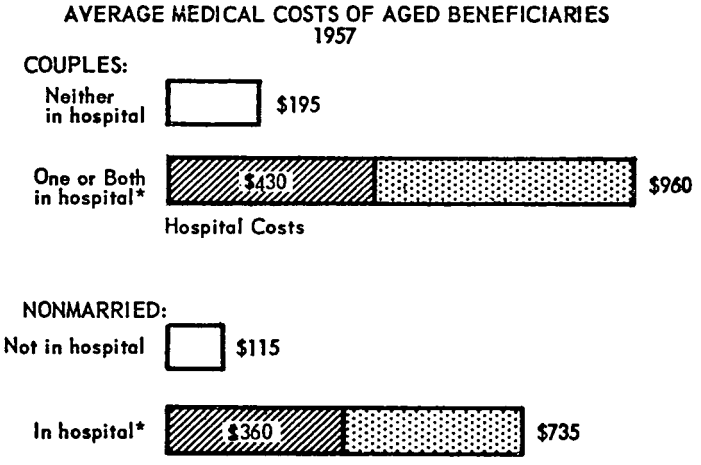
Drug expenditures: Amount by private individuals, by age, 12-month period, 1957–58

Age	Amount
Total	$19
0 to 5	14
6 to 17	9
18 to 34	13
35 to 54	22
55 to 64	31
65 and over	42

Source: Health Information Foundation, "Family Expenditure Patterns for Personal Services, 1953 and 1958" (Research Series, No. 14), p. 14.

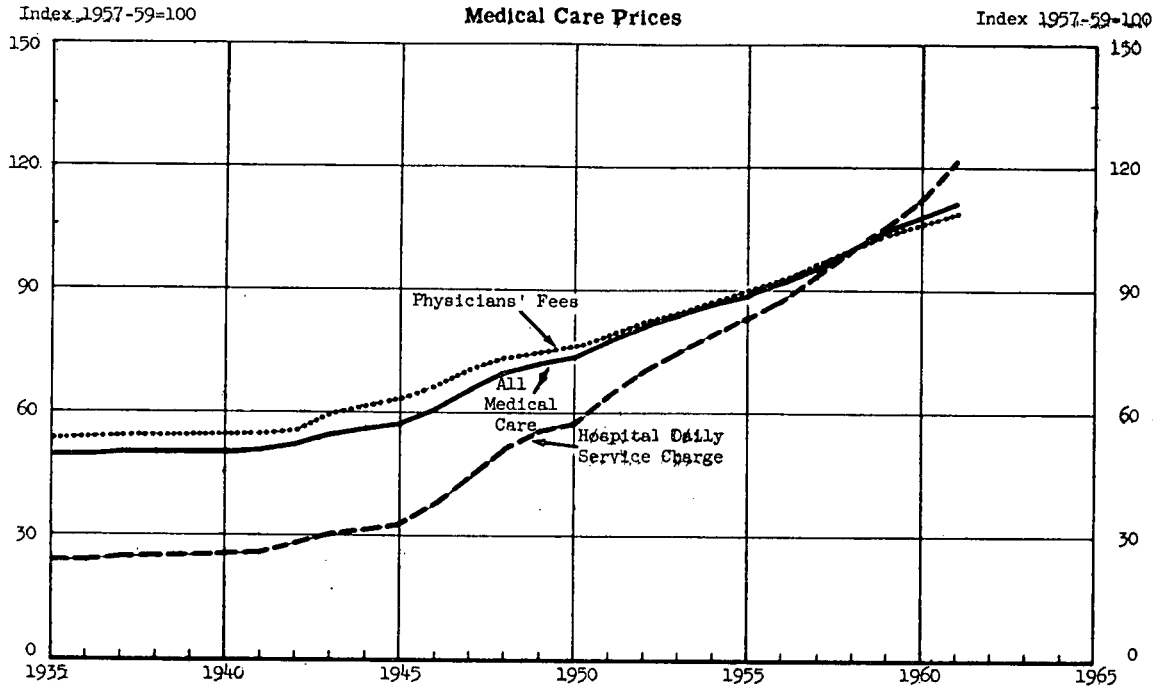
(D) As may be noted, the aged are great consumers of health services. In turn, it may be said that the costs of such services are great consumers of the resources of the aged.

In particular, expenditures for hospital care have the greatest impact upon the finances of the elderly. While the time of hospitalization is unpredictable, the need for such care is inevitable. One in six of the 65-and-over population is hospitalized one or more times annually. Nine of every 10 people aged 65 and over can expect to be hospitalized one or more times prior to death. The costs of hospital care are therefore of obvious and paramount concern. Hospital bills, the most expensive cost factor, are accumulated in the shortest period of time, are the least budgetable, and are the most disastrous to the financial well-being of older Americans. The effect of hospitalization upon the overall medical costs of the elderly is graphically illustrated in the following chart which is based upon a 1957 study of social security beneficiaries.



*General hospital; excludes persons in chronic-care institution only.

As obvious a drain upon the resources of the elderly as the 1957 survey indicates, the financial consequences of hospitalization are even greater today. In dollars and cents, the care that cost $26 a day in 1957 cost $35 in 1961 and an estimated $38 in 1962. During the period 1960 and through 1962 the average daily service charge for hospital care increased by an estimated 27 percent. There are various and valid reasons for the extremely rapid rise in hospital charges since the end of World War II. Nonetheless, the impact of this rise has become an extremely unhappy fact of life for millions of elderly Americans. Even those of the aged who were fortunate at one time or another to be able to secure some degree of protection through the purchase of hospitalization insurance have felt these often frail reeds slip or slipping from their grasp for increases in the cost of hospitalization insurance have even outstripped the rise in hospital charges.



Health, Education, and Welfare Trends

No other major items of consumer expense have experienced rises comparable to the increases in the costs of hospital services and hospitalization insurance. These two items are in a class by themselves. By way of comparison, during the period 1960 through 1962, the price of food increased by some 4 percent, clothing by about 2 percent, and housing by approximately 4 percent as compared with an increase of an estimated 27 percent in hospital service charges.

Consumer Price Index: Percent increase by category and for selected medical care items, 1950 to 1961 and 1940 to 1961

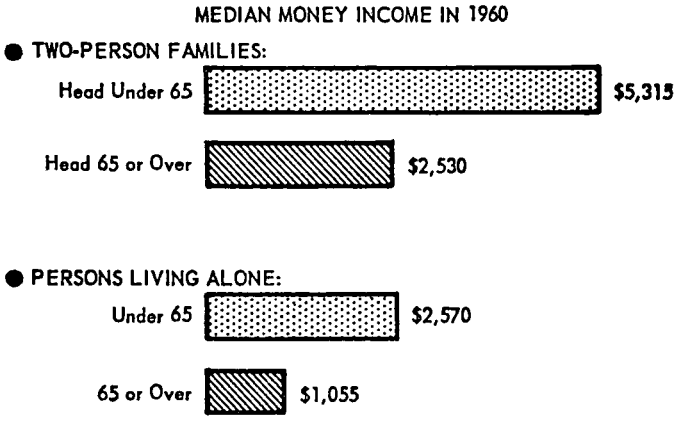
Item	1950 to 1961	1940 to 1961
All items	24.8	113.4
Medical care [1]	51.8	121.3
Hospital daily service charges	109.7	376.8
Physicians' fees	43.0	99.6
Dentists' fees	29.0	96.7
Prescriptions and drugs	16.7	45.8
Food	19.7	153.3
Apparel	12.3	107.1
Housing	24.9	73.4
Transportation	32.9	111.9
Personal care	32.5	125.2
Reading and recreation	20.0	93.6
Other goods and services	26.6	83.0

[1] Includes optometric examinations and eyeglasses not shown separately. Hospitalization and surgical insurance included in the index for 1961 but not for the 2 earlier years.

Source: Bureau of Labor Statistics, "Price Indexes for Selected Items and Groups."

(E) As has been seen, the expanded need of the elderly for health services has been accompanied by progressive increases in the cost of these services. These two facts of older life are accompanied by two other unfortunate realities—decline in income, and assets inadequate to compensate for insufficient or nonexistent income.

(1) Reflecting in large part the continuous decline in recent years in labor force participation by older Americans, median incomes of the elderly are less than half of that of the population under age 65.



Considered on an individual basis, somewhat more than half of the more than 17 million older Americans had incomes of less than $1,000 in 1960, with some 80 percent having less than $2,000.

That the income situation of the elderly is not worse than it is, is in large measure attributable to the increase in the numbers and proportion of the aged who receive income from public income maintenance programs. From the beginning of 1960 through June of 1962 the number of beneficiaries aged 65 and over under the old-age, survivors, and disability program increased from 10,068,000 to 11,976,000. During the same period the percent of the total population aged 65 and over eligible for OASDI benefits increased from 70.9 to 77.1 percent. The percentage of the aged population actually receiving benefits increased from 62.3 to 68.7 percent.

At the end of June 1962, recipients of old-age assistance—that is, of relief rather than or in addition to social security payments—under Federal-State programs, numbered 2,237,000, 12.8 percent of the aged population. About one-third of those receiving old-age assistance were also social security beneficiaries and represented about 6½ percent of all beneficiaries aged 65 and over. The Social Security Administration reports that about one-half of those currently going on the old-age assistance rolls are OASI beneficiaries. About 1 out of 10 aged persons receive benefits under the railroad retirement or Federal employees retirement programs.

While the social security and old-age assistance programs provide the elderly with billions of dollars annually, individual payments are not impressive. Under the social security program, the old-age benefit for a retired worker averaged $72.78 monthly in 1959. At the end of 1961 the average payment had increased to only $75.65. The average monthly payment under the old-age assistance (relief) program, including payments made to doctors for medical care and accepted by them, was $65.99 in 1959. At the close of 1961 the average monthly payment was $68.78.[6]

The latest data available concerning concurrent receipt of old-age assistance and social security benefits by an individual are for February 1962. The average OAA payment to such individuals (including direct payments to providers of medical services) was $55.48 compared with an average OAA payment of $78.87 to persons who were not beneficiaries of social security. The average social security benefit paid to recipients of OAA was only $47.28—more than $22 below the average monthly benefit for all beneficiaries aged 65 and over.

Average monthly payments under the railroad retirement and Federal employee retirement programs are higher than under the OASI and OAA programs. In mid-1962 the average monthly payment was $138 for a retired railroad worker and in mid-1961 the amount was $177 for Federal retirees.

The Social Security Administration estimates that 1¾ million older Americans were getting private retirement pensions in the middle of

[6] It should be noted that by the end of June 1962 the average monthly payment had ascended to the not impressive figure of $72.55. Of this amount, however, $14.49 represented payments by States to suppliers of medical services. Thus, the average monthly allowance for necessities other than medical care amounted to $58.06 in June 1962. Precisely the same sum, $58.06, as was allowed 2 years earlier in June 1960. In essence, then, increases in the average monthly OAA payments have resulted only from the fact that more States now employ the vendor payment method for medical care and some States have increased the amounts of such vendor payments.

1962, with the majority of recipients also being beneficiaries of social security.

Other forms of income available to some of the elderly include sums derived from privately purchased annuities, interest, dividends, rent, and cash contributions from relatives.

According to the Bureau of Labor Statistics, the cost of a retired couple's budget was estimated to have ranged from $2,641 to $3,366 in 20 large cities in the fall of 1959. This budget was predicated upon a "modest but adequate level of living" for a couple in reasonably good health living in rented quarters in an urban area.

It is quite apparent from the foregoing data on the incomes of the elderly that their incomes, on the whole, are inadequate to meet the budgets established—let alone the omnipresent threat of health costs. Assuming that the elderly who possess assets are not unwilling to utilize what they own to supplement or replace minimal or nonexistent income, it is important to ask what kind of assets are available to them and how valuable are those assets?

(2) Except for an owned home, few of the elderly have assets in substantial amounts. Those who do are more likely to be the relatively small number (such as physicians, lawyers, and engineers) who already have the advantage of higher income.

The 1960 Survey of Consumer Finances, conducted by the University of Michigan Survey Research Center for the Federal Reserve Board, found that among spending units with heads aged 65 and over, 30 percent had no liquid assets, and 20 percent had liquid assets valued at less than $1,000.[7]

Value of liquid assets: Distribution of spending units by size of holdings and age of head, early 1960

[Noninstitutional population of the United States]

Value of liquid assets	Age of head			
	65 and over	45 to 64	35 to 44	Under 35
Total	100	100	100	100
Do not own	30	22	20	26
Own:				
$1 to $199	6	11	18	54
$200 to $999	14	22	26	
$1,000 to $1,999	10	13	14	17
$2,000 to $4,999	18	15	12	
$5,000 and over	22	17	10	2
Median value:				
All spending units	$1,000	$800	$700	$400
Holders only	$3,000	$1,100	$900	$700

Source: University of Michigan, Institute for Social Research, Research Center, "1960 Survey of Consumer Finances," 1961.

Equity in a home is by far the most common asset of the elderly. Ownership of a home was reported by 64 percent of the older spending units in the 1960 survey. More than four-fifths of the homes were clear of mortgage debt. More than half of the homeowners reported the value of the home as less than $10,000. A 1957 survey of old-age

[7] A spending unit is defined to consist of related persons who pool their incomes. Married couples and their children under 18 are always considered members of one spending unit. Other related persons are separate spending units if they earn more than $15 per week and do not pool their income. Persons 65 and over living with and dependent on relatives (whose situation is not reflected by these data) almost certainly have fewer assets than the financially independent spending units with head aged 65 and over.

and survivors insurance beneficiaries found that about two out of three of the married beneficiaries and one out of three nonmarried beneficiaries owned a nonfarm home. While this survey also revealed that most of the homes were mortgage free, the equities were relatively modest—about $8,000 for married couples and widows and about $6,000 for single retired workers.

Thus, those of the elderly who have assets hold, in the main, assets of a fixed nature. These consist primarily of equities in homes. Liquid assets are either nonexistent or so limited as to afford no long-term chance of weathering the financial storms which accompany illness. What was so carefully husbanded to supplement meager income in purchasing basic necessities—food, clothing, housing—often vanishes in a flood of medical expenses during a few brief weeks or is quickly drained away by the never-ending costs of chronic illness. And, again, the assets of the elderly—sum and substance of a lifetime—are irreplaceable.

In the preceding section we have outlined in summary fashion the dimensions of the health problems of the elderly.[8] It is also quite obvious that the elderly, as a group, do not have sufficient income to support what may be considered an adequate standard of living exclusive of the demands upon their resources that are made by their health needs. Their principal assets are their homes. Surely the modest equities possessed after a lifetime of struggle should not have to be sacrificed to meet the expenses of circumstances over which they have no control. The younger man can restore and increase his assets after an illness—the older man can only lament and with reluctance and a great sense of shame, line up for public "relief." In the first half of 1961, just about every third person approved for old-age assistance—"relief"—needed it directly or indirectly as a result of health difficulties.

Two techniques purported to relieve the elderly of the intolerable burden of direct financing of health expenses are currently hailed in some quarters as present or potential solutions of the problem. These are private health insurance and the Kerr-Mills medical assistance for the aged program. The two sections which follow discuss the inadequacy of these methods of financing health expense.

II. Eleventh-Hour Attempts by Private Health Insurers To Cope With What Is, in Terms of Their Underwriting Philosophy, the Insoluble Problem of Providing Adequate Benefits at Acceptable Premiums for a High-Risk, Low-Income Segment of the Population

In evaluating the efforts of private insurers toward making health insurance available to older Americans, it is helpful to understand the scope of coverage generally offered. Once this is understood the gaps in protection against the broad range of health expenses becomes apparent—even for those of the elderly who are fortunate enough to have some degree of insurance protection.

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[8] This committee has played a major role in the acquisition and distribution of information defining and discussing these and other problems of the elderly. More detailed data and personal accounts are contained in the various studies and reports of hearings held by this committee. A complete bibliography of publications may be found in appendix A.

Conventional health insurance is hospital oriented. Benefits, to the extent they are provided, generally relate to charges made by a hospital for its various services, and the fees charged by doctors for medical and surgical care rendered at the hospital. Relatively few basic health insurance plans afford any coverage for the very significant range of expenses incurred outside of the hospital. Included among such expenses are doctor's fees for home and office visits, the cost of drugs, dental care, and special nursing services. The best available information indicates that these nonhospital items account for more than 50 percent of the annual health expenditures of the elderly.

It is also true that the emphasis upon hospital expense is justified. Hospital expenses are the most unpredictable in terms of occurrence and have the greatest impact in the shortest period of time. They are the most expensive, least budgetable and therefore the most disastrous. But concentrated insurance coverage is not comprehensive coverage. Medical expenses other than those for hospital care also constitute substantial claims upon the meager resources of the elderly. The financial impact of these expenses is staggering—particularly when coupled with hospital expenses. Obviously, older Americans would find nonhospital expenses more manageable if relieved of much of the burden of direct hospital expenses and/or the cost of hospitalization insurance. And, obviously, insurance companies could offer policies materially assisting with such expenses if hospital costs were otherwise provided for.

Several interrelated questions must be considered in any discussion of private health insurance and the elderly:

(1) How many older Americans have health coverage?
(2) How available is health insurance?
(3) What kinds of health insurance are offered and what limitations and exclusions accompany these offerings?
(4) To what extent does present coverage meet health expenses?
(5) How much must the elderly pay for health insurance?

How many older Americans have health coverage?

The national health survey provides the most reliable data on the extent of health insurance among the various age groups. These data indicate that just over one-half of the elderly have some form of health insurance—principally hospitalization coverage. A survey conducted during the period July-December 1959 revealed that, among elderly persons, 46 percent had some form of hospitalization coverage, 37 percent had surgical insurance, and 10 percent had some insurance coverage for doctor's visits. The respective figures for the general population were 67, 62, and 19 percent. A significant but predictable finding of the survey was that a far smaller percentage of persons 75 years of age and over had any health insurance as compared with those 65 through 74 years of age.

Age group	Hospital	Surgical
65 to 74	53	44
75 and over	32	24

Another equally significant and equally predictable finding of the survey was that elderly persons with the lowest incomes have the lowest percentages of coverage. Only one-third of aged persons with family incomes of less than $2,000 have any form of hospitalization insurance.

Insurance coverage of aged persons: Percent of aged persons with hospital insurance by income, July to December 1959

[Noninstitutional population of the United States]

Family income	Percent
Total	46.1
Under $2,000	33.3
$2,000 to $3,999	53.2
$4,000 to $6,999	59.6
$7,000 and over	59.4

Source: Public Health Service, U.S. National Health Survey, "Interim Report on Health Insurance United States, July-December 1959" (Publication No. 584-B26), December 1960.

Availability of health insurance

Nonprofit health plans, such as the various group practice plans and Blue Cross and Blue Shield have made efforts toward offering the older person an opportunity to enroll in their programs. In recent years, they have been joined by the commercial insurers who were stimulated, perhaps, by fear of the stereotyped spectres, ghosts, goblins, ogres, and declarations of Armageddon that are evoked whenever social security financed legislation is considered.

Over the years Blue Cross and Blue Shield have permitted the retiree to continue his coverage if he was insured at the time of retirement. Often the coverage afforded provides less benefits at higher cost than the group coverage held prior to retirement. Not only does the retiring employee who converts his coverage often have to accept lower benefits at greater cost but his out-of-pocket costs are further increased by the loss of, or decrease in employer contribution.

In recent years there has also been a tendency for retirees to be continued as members of the active employees' group. In some instances this involves different benefits, rates, and extent of employer contribution. In other instances the benefits and rates parallel those of the active employees. Three factors are operative in these situations which may very well inhibit further growth of this enrollment technique. First, is the growing departure from community-rating methods and substitution of experience-rating methods. That is, basing charges upon the expenses of a particular group or groups rather than calculating charges on the experience of the community as a whole. Second, as the ratio of retirees to active employees increases the cost of coverage may become prohibitive for the group—despite good intentions. Third, the continuation is usually predicated upon length of participation as an active employee. Thus, a very high percentage of persons retiring from firms which have such programs cannot qualify to continue in the group. These are employees who have not served the requisite 5, 10, or 15 years necessary to qualify. This is quite understandable in a nation where job mobility is at a high rate.

In addition to these group conversion and continuation contracts, most Blue Cross and Blue Shield plans offer individual or nongroup contracts with opportunities for enrollment at periodic intervals. However, as of January 1962, some 60 Blue Cross plans would consider only applications submitted by persons under specific age limits.

Prior to 1962 a small number of Blue Cross plans—some 12 or so—commenced offering special "senior certificates." The principal virtue of such coverage was that no age limit conditioned eligibility. In virtually every instance, however, the coverage was far more limited and far more expensive in relation to the benefits available to other Blue Cross subscribers. The younger and healthier and wealthier got the most coverage at the lower rate. The elderly, sicklier, poorer group got the least coverage and at a higher rate. Exactly the reverse of what is socially desirable.

In a special report released in January 1962 the Blue Cross and American Hospital Associations conceded the desperate need of the elderly for adequate health insurance. With much fanfare the American people were led to believe that Blue Cross, as it had in the 1930's, would provide a definitive answer to a national problem. In a series of intermittent announcements and interviews—exquisite but obvious in their political timing—the Blue Cross Association indicated that a national program offering adequate benefits would be offered to the elderly on a uniform basis throughout the country.

In a press release dated January 6, 1962 the president of the Blue Cross Association announced "* * * the historic decision taken by the Blue Cross plans of the United States to finance a program of comprehensive health care benefits for the aged, with assistance from the Government to those retired aged who need help in purchasing it." The same release went on to indicate that the outlines of the program had been presented at a special meeting of the Blue Cross and American Hospital Associations. To be included in the national program were benefits for care in acute hospitals, chronic hospitals, nursing homes, outpatient clinics, and visiting nurse services. All that remained was "* * * organization into technical language to implement the general approval * * *" The meeting of the associations and the resultant press release occurred just prior to the convening of Congress with hospital insurance for the elderly an obvious and significant legislative item.

With reference to the "new" program, the president of the Blue Cross Association, Walter J. McNerney, was quoted in the February 2, 1962 issue of Medical World News as follows:

> If we are to have an impact on Congress, we should be tooled up in a couple of months. If we must be ready earlier, we will be.

This appearance of candor was, unfortunately, not accompanied by the appearance of the program that had been promised.

Commenting on the "new" proposal, the Chicago Sun-Times said on January 22, 1962:

> Now with Congress again facing the issue it is encouraging to note that the foes of the administration's plan have produced an alternative proposal which is well worth examining.

On April 21, 1962 the Scripps-Howard papers carried a story indicating that the new Blue Cross program might be available in July. Similarly deceived was the Republican Policy Committee which in May 1962, in its official chart of legislative proposals, in all good faith set forth the details of the nonexistent Blue Cross program as if it were a reality rather than the myth it was and still is.

This drive was designed to head off a program of hospital and related benefits financed under the social security system.[9] It culminated at the end of September—short weeks prior to the November elections—when full-page advertisements were placed in national magazines by the Blue Cross Association. These advertisements heralded "new" and "expanded" programs for the elderly which were or would be made available that fall. No mention of the national program promised earlier in the year. Interested readers were urged to contact local Blue Cross plans for full details of these millennial offerings. At least 33 Blue Cross plans were unable to provide the "full details," when originally contacted. The extremity of the compulsion upon the Blue Cross Association to make "something" available to the elderly may be deduced from three facts. First, Blue Cross has testified that in a recent year it received an estimated $200 million in premiums from its over-65 subscribers but that the costs of covering this segment of its enrollment was $375 million. Secondly, Blue Cross plans have been under constant public pressure as a consequence of their frequent requests for substantial increases in premium rates. Additional coverage of the elderly could lead only to further strain in this area.

Finally, in recent years Blue Cross plans have been virtually noncompetitive with commercial insurers in the race for acquisition of the prime groups of employees. This has been true because as a result of community rating the Blue Cross rate structure has, quite commendably, borne the added burden of underwriting high-risk groups. Commercial insurers have stepped nimbly to one side and walked away with the low-risk groups by means of ratemaking based solely upon the experience of such groups. If the legislation we advocate were enacted, Blue Cross, relieved of the burden of basic underwriting for their older subscribers—nongroup and group conversion—might have and may still become a vigorous, dynamic, and expanding organization with principal concentration upon provision of adequate hospital insurance for the younger population.

The staff of the committee is presently engaged in the preparation of a report evaluating the programs for the elderly offered by the various Blue Cross plans this last fall. The initial diagnosis, however, is that it was no more than another episode of a chronic condition—too few benefits at too great a cost.

With regard to the offerings of the commercial insurance carriers, the majority of companies will now accept applications for individual health insurance policies from individuals up to 70 or 75 years of age and in some instances without age limit. Premium charges for persons in the older ages are as much as double those for younger people and the benefits are often less. The large majority of these

[9] The Scripps-Howard newspapers carried a story dated Apr. 21, 1962, which included the statement that the "American Medical Association is pressuring Blue Cross to act fast to head off the Kennedy administration's plan for medical care under social security. Aim is for a uniform, nationwide, low-cost policy available at once for the elderly."

individual or nongroup policies are renewable only at the option of the insurer. Insurance companies have not hesitated to refuse renewal to policyholders who have suffered ill health.

A number of the larger insurance companies, however, now offer guaranteed renewable and/or noncancelable individual policies. Rates may be increased on these policies but generally only if rates are raised on all policies of the same class.

That the commercial insurance industry is somewhat unsure that guaranteed renewability is "good business" is apparent from the following excerpt from a speech delivered by James E. Powell, vice president of the Provident Life & Accident Insurance Co.: [10]

> Renewability of hospital-surgical coverages, while not the problem it was at the time of the HIAA recommendations of December 1958, still represents some unanswered questions. If we continue to agree not to terminate coverage solely because of deterioration of health, should we not go all the way and make even our outstanding optional renewal business genuinely guaranteed renewable?
>
> On the other hand is guaranteed renewability actually in the public interest in all cases? Guaranteed renewability for life is a very popular proposition today. But what happens when either we solve this question of mass coverage for those over 65, with no questions asked or, failing that, the Federal Government gets into the act. How much antiselection do we create by letting people continue to renew our policies despite other and cheaper coverages which may be available? What effect will such antiselection have upon future rates for persons in the younger ages, or upon the surplus of our companies?
>
> I realize that some companies are attempting to handle this matter by policy wording. But without any basis of law, will such handling stand up in court? In order to be on safe ground in this area, legislation may be desirable, although the prospect of trying to pass any uniform statute in 51 jurisdictions is a frightening one.

Various commercial insurers have adopted the technique of mass enrollment in an effort to reduce sales expense and to bring some of the efficiencies of group underwriting to individual policies. These policies are sold during limited periods and without requirement of a health statement.

A variation of the mass enrollment technique is employed in a few States such as Connecticut and New York. In these States, special legislation authorized a group of companies to "pool" their offering to the elderly. That is, a single program, such as Connecticut 65, is offered by the several participating companies with all of the participants sharing the premiums and risk.

These new enrollment methods of some of the private health insurers have improved the commercial health insurance picture to a degree. But the number of elderly enrolled is still low and the loss ratio is understood to be high.

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[10] Presented before the Individual Insurance Forum of the Health Insurance Association of America, on Oct. 29, 1962, in Chicago.

The mass enrollment policies are open for enrollment at specified times only. This means that the older individual who seeks coverage must have the necessary funds available at the time an offering is made. Otherwise, his recourse is to apply for coverage that often provides substantially less protection for substantially more money and which generally requires the submission of a health statement.

What kinds of health insurance are offered and what are the limitations and exclusions accompanying these offerings?

The health insurance made available to the elderly by commercial insurers is invariably of an indemnity nature. Unlike many Blue Cross plans or the King-Anderson, McNamara, and similar social security proposals which provide stipulated services, benefits are payable in terms of fixed dollar maximums and not in terms of the services required. There is increasing use made, however, of the major medical approach. A major medical policy usually offers coverage for a broader range of services than does a basic health policy. Benefits are usually payable without dollar limit on the individual services—although there is increasing use of limits on the hospital daily room and board charge and surgical fees. Benefits are available to a single maximum amount on all services covered. The disadvantage of this type of coverage for the elderly is that the older person must first pay a specified amount toward his medical expenses before he is eligible for any reimbursement. These deductibles usually range from $100 to $500. Assuming he can pay the deductible, the older individual must then be prepared to coinsure his expenses. That is, the major medical contract will pay for only 75 or 80 percent (sometimes less) of the charges in excess of the deductible. Where income is low, the deductible tends to inhibit the seeking of that early and timely care that so often prevents serious illness. Both deductibles and coinsurance are artificial financial devices to limit liability. They bear no relationship to need. Except to the most minor degree such devices cannot be considered as suitable for the needs of the high-medical expense, low-income elderly.

Unfortunately, many Blue Cross plans do not make service benefits available to most of the subscribers in their areas. (The term "service benefits" encompasses the provision of coverage in the form of the services required without dollar maximums.) However, a number of these plans do offer a mixed bag of benefits in instances. For example, a $12 daily allowance toward hospital room and board charges and coverage in full for drugs supplied by the hospital.

Other Blue Cross plans, on the other hand, have fulfilled their promise to provide service benefits—but not always for their elderly subscribers who are most in need of such coverage. The survey of Blue Cross benefits for the elderly, now in process, shows, very clearly, a marked increase in the use of indemnity benefits, deductibles, and coinsurance by Blue Cross plans. This development is interesting to note in that the president of the Blue Cross Association, Mr. Walter J. McNerney, has termed the use of deductibles and coinsurance as "fiscal gadgetry." The statement is praiseworthy for its accuracy, if not its acceptance by members of his organization.

Apart from the fact that the older person is generally offered less in terms of the actual benefits payable for a covered illness, he is also discriminated against in more subtle, yet equally harmful fashion. He may find his application rejected because of his health history (admittedly not too subtle). If his application is accepted and his policy issued he will often find that the obligation of Blue Cross and Blue Shield or the commercial insurers is sharply reduced by an assortment of limitations and exclusions.

Assuming that the older applicant for nongroup Blue Cross and Blue Shield coverage can satisfy the age requirement (or has a local plan which offers a special "senior certificate") he must very often cope with another hurdle on his path toward limited protection. Based upon data as of January 1962 the great majority of Blue Cross and Blue Shield plans required that the nongroup applicant submit a health statement. If the statement indicates that the applicant is a poor health risk he is apt to have his application rejected or be issued a contract excluding or limiting coverage for specified preexisting conditions. On the other hand, even if his health history is acceptable, he is often required to wait specified periods of time—from 6 months to as long as 2 years—before any coverage will be available for specified types of illness. This is true despite the fact that such illness may occur after the effective date of his contract and in a period during which he has been paying money for protection. Such restrictive underwriting is not, however, peculiar to Blue Cross and Blue Shield—it is standard underwriting procedure for virtually all private health insurers. It is the sort of procedure that tends to guarantee the financial health of the insurer rather than the insured.

To what extent does health insurance meet the expenses of the elderly?

Simply stated, private health insurance has not come even close to meeting the health expenses of those insured—let alone those millions without any coverage whatsoever.

In an extensive study sponsored by the Ford Foundation and the Brookings Institution, Herman M. Somers and Anne R. Somers stated:

> The fragmentary evidence available suggests that health insurance does not meet more than one-sixth of total medical costs of the insured or one-fourteenth of the total for all the aged.[11]

Somewhat more than fragmentary is the chart on the following page, which is based upon data developed by the National Health Survey.

Obviously relatively few of the elderly share in the hospital insurance "pie"—and, for those who do, the portions are often small. Hospital insurance coverage is, by far, the predominant form of insurance held by those of the elderly who have coverage. The poor picture presented is, therefore, far better than that for the other items of health expense.

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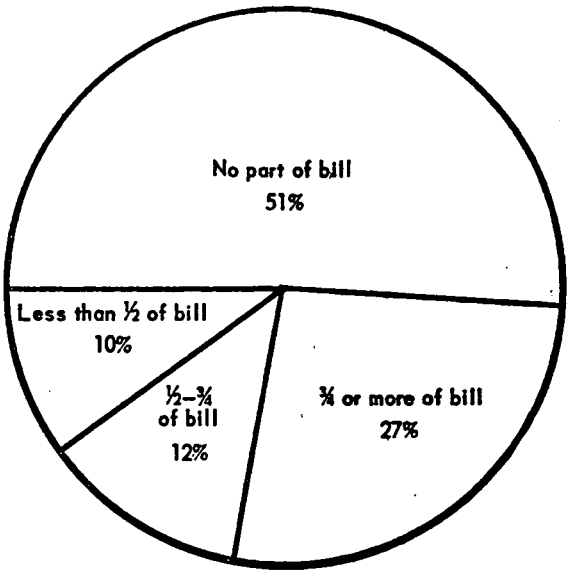
[11] In *Doctors, Patients, and Health Insurance,* Somers, H. M. and A. R., Brookings Institution, Washington, D.C., 1961.

For a majority of the hospital stays of the aged, insurance pays less than half of the bill.

PORTION OF HOSPITAL COSTS MET BY INSURANCE FOR EPISODES IN SHORT-STAY HOSPITALS, 1958–60



The vice president of the Provident Life & Accident Insurance Co., in the same speech previously referred to, said:

> * * * Far too many of our policies, designed to furnish adequate protection when they were issued back in the fifties, do not provide the benefits necessary to meet today's greatly increased costs.

The gentleman was speaking of all commercial health insurance policies, not specifically of those issued or available to older persons. While it is arguable that the policies issued back in the fifties were ever adequate, it is unquestionable that the private health insurance available to the elderly today is inadequate—and expensive.

How much must the elderly pay for health insurance?

Premiums paid by the elderly for health coverage may be considered in two contexts: The actual cost of an individual policy, and the return in dollar value of benefits in relation to dollars paid in.

The individual monthly cost of health insurance which includes benefits for hospital and surgical care can range as a practical matter from $2 or $3 to as much as $30. Preliminary examination indicates that, where available, the newer Blue Cross and Blue Shield programs for the elderly average some $15 monthly per person. The premiums charged, of course, are not always indicative of the benefits provided. A $15 premium in, say South Carolina, should purchase far more than an equivalent payment in California.

The Continental Casualty Co.'s widely advertised "golden 65 Plan"—which claims to offer "complete coverage" for the older person carries a premium cost of $252 a year for an individual—$504 annually for a couple.[12]

Obviously the premiums charged constitute a very heavy drain upon the resources of those very few of the elderly who are able to get this coverage.

On the other hand, the extremely high premiums serve as a complete barrier to the acquisition of necessary protection by millions of other elderly individuals. It will be recalled that more than half of our older Americans have annual incomes of less than $1,000. And, as previously discussed, even where insurance is held it provides only partial protection—large additional sums must be paid out of pocket.

In 1961 commercial insurance companies returned only 53 cents in benefits for every $1 collected as premiums for individual health policies. The balance—47 cents of every single dollar—was allocated to commissions, profits, and administrative costs rather than to payments for health services.

The new mass enrollment policies have made some attempt to increase the percentage of payout. But they still return only an estimated 75 or 80 cents on the dollar. The "Connecticut 65" plan hopes to pay as much as 85 percent in benefits in the future. This is a nonprofit program operated by a group of insurance companies in that State.

In contrast to the high insurance company retentions under individual policies, the payout on group insurance is some 90 percent. Blue Cross and Blue Shield—including nongroup subscribers—return approximately 92 percent of the subscriber dollar.

In comparison with all of these rates of return, the estimated costs of administration of providing hospital and related benefits under the social security system are only 3 percent.

The study by Dr. and Mrs. Somers, previously referred to, contains some rather telling observations on the relatively futile efforts of the insurance industry to cope with the needs of the elderly:

> It is ingenious enough to devise almost any kind of policy, at any level of benefits, that people are able and willing to buy. But this is the rub. The coverage they can afford to buy offers very little protection. The coverage they need, private insurance cannot offer at an actuarially sound price. Clearly, effective health insurance for the aged requires substantial spreading of costs to other segments of the population. But the competitive and voluntary nature of private insurance precludes the authority required to merge the costs

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[12] For this premium the insured would receive a basic hospital-surgical plan allowing $10 daily to a maximum 31 days for hospital room and board cost (the average daily room and board rate for all types of accommodations in U.S. hospitals is now estimated to be about $20); $100 for hospital "extras"; and an inadequate $200 surgical schedule. The major medical expense plan which provides supplemental coverage for in-hospital expenses only, not only has a $500 deductible and a $10,000 lifetime maximum, but also contains strict limitations (internal) on eligible expenses; $25 daily maximum for room and board, $10 per day for nursing home care; $300 surgical schedule; $4 for doctor's visits to hospitals; and $6.50 for a visiting nurse. Similar restrictions apply to the out-of-hospital expense coverage. This plan has a $100 deductible and a $5,000 maximum, with the following internal limitations: $6.50 for doctor's house calls; $5 for visits to doctor's office, and a fixed schedule for X-ray and laboratory work. It should be understood that the plan does not pay the amount of the internal limitation, but only a percentage of the charge up to the limitation. For example, it pays 75 percent of the first $5 of the charge for a visit to the doctor's office.

of a special high-cost low-income group with balancing sectors of the population. It is significant that about two-thirds of the aged with any health insurance in 1958 were enrolled in Blue Cross or independent plans, which have a deliberate policy of at least partial community rating. But, as we have seen, the aggressive competition of experience-rated insurance is increasingly threatening their capacity to continue this business.

Does the future bear promise of significant improvement? Unfortunately not. The aged will increase as a proportion of the population. Their finances may improve a little. They will have more education and greater health consciousness. Many more will be accustomed to the benefits of health insurance in their earlier years and will want to continue it. On the other hand, an increasing proportion will be concentrated at the later years when illness becomes more frequent and income is even lower. The problem of insuring persons over age 70 is more formidable than at 65–69. Women, whose medical costs are higher, will be increasingly in the majority. Most will be widows living alone or with persons not relatives—an unpromising social situation from a medical viewpoint. Medical prices, particularly hospitalization, will continue to rise.

Does all of this signify that the demonstrated inability of the private health insurers to provide adequate basic coverage at acceptable premiums precludes any major role in the future in meeting the health insurance needs of older Americans? Several leaders of the industry think not. It is their feeling that the "floor of protection" that would be provided under a federally sponsored hospital insurance program would provide broad opportunities for growth in the underwriting of supplemental health insurance.

Early in 1962 the medical director of the Continental Casualty Co.—the same company that offers the "golden 65" program—stated:

> Back in 1935 many insurance firms predicted that if the social security program were enacted nobody would bother to buy life insurance as a financial hedge for their old age. But they were dead wrong and life insurance sales have soared to new highs.
>
> Similarly, I think that if the President's health care of the aged bill is enacted, private companies will sell more health insurance than ever before. And they'd do it by offering policies insuring the individual against (1) physicians' fees and surgery, and (2) medical care beyond the limits of the bill.
>
> It's no secret that the chief reason private health insurance for the elders costs so much today is because a certain percentage of these people require excessive hospital care.
>
> With these costs largely absorbed by this health plan under social security, private companies will be able to devise policies covering physicians' fees and extended care at such modest cost that greater numbers of elders than ever before will be inclined to buy them as an extra safeguard against costs of serious illness.

Awareness of the beneficial effect upon the insurance industry that would result from establishment of a program of social security financed hospital care for the elderly has also been indicated by another highly responsible and concerned individual. Hastings Keith, of Massachusetts, a distinguished Republican Member of the House of Representatives until January 1963, and former district manager for the Equitable Life Assurance Society, characterized the King-Anderson bill as the "true conservative approach to a problem we can no longer ignore."

III. The Passage in Late Summer of 1960 of the Kerr-Mills Act, Which Attempted To Solve the Problem by Means of the Creation of a New Category of Persons Eligible for Public Assistance—the Medically Indigent Aged

The committee has closely observed the progress—or rather lack of progress—of the Kerr-Mills medical assistance for the aged program since its enactment in September of 1960. In 1961 and 1962 the staff of the committee prepared comprehensive studies reporting and evaluating the half strides in the hesitant parade of Kerr-Mills, MAA.[13]

Careful and continuous observation of the medical assistance for the aged program has led to the inescapable conclusion that MAA, by itself, cannot now nor in the future constitute an effective national solution to a national problem. Too many millions of older Americans go without help in the 25 States which still do not have MAA programs in operation more than 2 years after enactment of Kerr-Mills. And within most of these States which have the form of MAA plans, the substance of the programs denies or affords ineffective assistance to other millions.[14] Kerr-Mills offers too little, too late, to too few.

There are inherent defects in the Kerr-Mills approach which render it an inadequate answer and which are not susceptible of amendment. First, in order to effectuate a program and secure Federal grants a State must be able to provide matching funds of its own. With the exception of a few wealthier States, the ability of the States to raise funds for this purpose is either nonexistent or severely limited. Where programs are in operation they are invariably restrictive. They are not designed to meet the full range of health needs of all those who need help but rather, are tailored to eke out the funds available.

The resultant restrictions also create an undesirable additional strain upon State finances. Restrictive programs—both in eligibility and content—require an inordinate amount of policing and paperwork. The resultant effect is extremely high costs of administration. In one State, for every $1 in actual benefits the State paid $1.24 in administrative expense. This is particularly severe inasmuch as the State had to contribute half of every dollar of administrative cost but only 20 cents of every medical care dollar.

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[13] State Action To Implement Medical Programs for the Aged," June 8, 1961; "Performance of the States—18 months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program," June 15, 1962. A third report is now in preparation.

[14] Kentucky, for example, provides only 6 days of hospital care per admission and then only in the case of "acute, emergency, or life-endangering conditions." Oregon authorizes up to 14 days of hospital care per year with the recipient required to pay $7.50 daily toward charges incurred during the first 10 days. These are not isolated illustrations but typify restrictions and limitations upon the various types of services authorized.

The inability of the States to allocate adequate funds to Kerr-Mills MAA is not surprising in view of the fact that most States cannot even provide appropriations adequate to meet the basic needs of their admittedly completely indigent citizens. A table, set forth below, prepared by the Bureau of Family Services for the Advisory Council on Public Assistance, revealed that in 1960, most of the States failed to meet their own standards of needs for the aged on their old-age assistance rolls—people on relief. Obviously, a State that cannot now adequately provide basic necessities for its most disadvantaged people cannot be expected to give priority to a new medical assistance program for people who are better off.

Average monthly amount of income required and income provided per recipient, by State, July–September 1960

State	Total recipients	Requirements	Total available
Total	2,336,595	$84.63	$80.74
Alabama	99,139	78.63	66.94
Alaska	1,432	93.56	93.04
Arizona	13,977	83.99	79.07
Arkansas	55,781	61.66	58.77
California	254,401	125.72	117.90
Colorado	50,809	110.09	110.09
Connecticut	14,065	122.37	122.37
Delaware	1,270	66.70	65.25
District of Columbia	3,072	82.08	82.08
Florida	69,050	74.38	70.68
Georgia	96,523	57.40	55.78
Hawaii	1,434	71.44	71.44
Idaho	7,169	87.06	87.06
Illinois	70,970	74.50	74.02
Indiana	26,497	64.97	64.26
Iowa	33,460	91.10	91.10
Kansas	27,882	82.21	82.21
Kentucky	55,951	62.83	59.32
Louisiana	125,362	96.43	87.55
Maine	11,655	91.15	85.51
Maryland	9,662	70.60	70.60
Massachusetts	76,583	117.69	117.68
Michigan	60,510	93.82	86.29
Minnesota	44,933	85.53	84.27
Mississippi	80,081	54.29	48.48
Missouri	115,015	92.23	80.72
Montana	6,745	90.54	90.53
Nebraska	14,730	82.97	81.57
Nevada	2,600	109.69	109.69
New Hampshire	4,931	78.35	77.38
New Jersey	18,950	108.72	108.72
New Mexico	10,963	70.13	70.13
New York	78,468	115.82	115.82
North Carolina	48,266	60.41	54.19
North Dakota	6,982	82.68	82.68
Ohio	87,419	82.78	82.74
Oklahoma	88,289	82.30	82.20
Oregon	16,571	99.07	99.07
Pennsylvania	50,101	80.96	80.96
Puerto Rico	38,855	18.73	8.59
Rhode Island	6,755	89.78	89.78
South Carolina	31,945	48.29	47.51
South Dakota	8,709	74.23	74.23
Tennessee	54,442	53.37	51.48
Texas	221,727	70.18	67.66
Utah	7,759	83.35	81.89
Vermont	5,554	86.13	83.86
Virgin Islands	511	26.94	26.94
Virginia	14,552	60.35	60.32
Washington	48,283	100.56	100.27
West Virginia	19,185	44.72	39.55
Wisconsin	33,373	85.77	85.35
Wyoming	3,227	87.25	84.73

Second, the Kerr-Mills program is not designed to prevent indigency. Where it does function MAA comes into play only after the irreplaceable resources of the older person have been virtually exhausted by medical expense. By way of contrast, a program of hospital and related benefits provided under the social security system would afford protection when needed. The care would be immediately available without requirement that an individual virtually pauperize himself in order to secure aid. Preservation and protection of the financial resources of the older person is the goal. The social security approach nurtures and furthers independence. The Kerr-Mills approach is predicated upon dependence.

Only three States—and possibly a fourth—have MAA programs that meet the Department of Health, Education, and Welfare's definition of a comprehensive medical care program. The other States often limit their programs in terms of types of care provided, the duration or quantity of services supplied, in addition to specifying that benefits will be available only for certain types of illness or injury.

In some States, the medically indigent person is required to make cash contributions from his meager resources toward the cost of care. Occasionally, he must make such payments before he can even qualify for MAA help. As has been stressed in previous reports, such provisions are contradictory and self-defeating.

Limitations are frequently imposed upon the amounts payable for specific services. This is particularly true in the case of benefits for nursing home care. Where such care is authorized, the payments are often no more than enough to provide a poor quality of custodial care, and are totally insufficient to pay for any skilled nursing care. MAA funds were and are intended to purchase medical assistance—health services. It was not and is not the intent of the Congress that they be used to turn human beings into human vegetables, immured in substandard homes, receiving only bed and board, removed from our consciences by being hidden from sight.

Another apparent distortion of congressional intent that has occurred in the implementation of MAA by the States has been in the wholesale transfer of persons from other public assistance programs to MAA. The Congress had intended Kerr-Mills to represent a new program for new people not indigent and not already on relief. At the end of December 1961 about one-third of all persons whose eligibility for MAA had been approved were transferees from other relief programs. And many of the new cases now being listed as MAA beneficiaries would undoubtedly have received care under one or another of these other programs had Kerr-Mills not been enacted.

In this respect, Kerr-Mills does not, in large part, represent a new program for a new group of senior citizens. It represents, instead, a convenient device for transferring to the Federal Government most of the costs to the States of old programs for destitute people.

Among those States which have enacted MAA programs only one individual out of every 100 persons 65 years of age and over received any MAA help in September of 1962. For the Nation as a whole, only about 1 in 200 received any aid in September. This extremely low number of beneficiaries is certainly at variance with the demonstrated high incidence of illness of the elderly. It is also at variance

with the estimate by the Finance Committee that some 10 million older Americans were potential beneficiaries of Kerr-Mills MAA.

The minimal number of those actually helped in relation to the vast numbers who need help is the product of several factors. First, the existence of benefit limitations, in kind and extent, often exclude the provision of the type of care required by an older person. For example, an older American in need of skilled nursing home care could obviously not secure such care in a State whose MAA program did not include a benefit for such service. And even if he resided in a State that included a nursing home benefit, the limitation on the amount payable for care might very well preclude his receipt of skilled nursing home care. In effect, the amount allowable could only cover the cost of custodial care without any of the medical services required.

Secondly, there is the fact that millions of elderly persons in need of assistance are effectively "screened out" by restrictive tests of income and assets. These means tests, apart from any degrading qualities, are the basis of all relief programs.[15] The staff report of June 15, 1962, to which reference has been made, noted at least 15 States in which the means test for MAA serves to disqualify even those people who qualify for relief in those States.

For example, an elderly individual with an income of $1,500 whose anticipated needs amount to $2,000 might be considered eligible for medical care under the relief program. In the same State, however, the individual with this same income would automatically be "cut off" from MAA assistance regardless of his needs. The reason for this is that in most instances, under OAA, needs are weighed against total resources available. Under MAA, with arbitrary "cutoff" points, they are not.

Is there not a basic inequity in any "hard and fast" test which rules that an individual with income of $1,499 is "in" for full benefits while another with income of $1,501 is "out," and not entitled to any benefits whatsoever? The trend in congressional thinking is away from such "in or out" tests, as evidenced by the relatively recent introduction of a sliding-scale of pension benefits under veterans legislation and by the significant change in the retirement test under social security (to pay $1 in benefits for each $2 of earnings above the exempt amount).

A highly criticized aspect of the means test which appears to have incurred the condemnation of all who have studied and worked with it, are those provisions relating to "family responsibility." These provisions require that the income and assets of relatives be considered in ruling on an application for MAA help. In effect, the relatives of an applicant are also called upon to undergo a means test.

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[15] The investigations and certifications of the income and assets are often complex, embarrassing, and discouraging to both applicants and potential applicants. They frequently have the quality or reputation of "paupers' oaths."

Recognizing this problem, Senator Dirksen proposed an amendment (passed by the Senate in 1962 but dropped in conference) which would provide that an applicant's statement as to his financial status, if made under oath shall be "presumed to be factually correct for purposes of determining his eligibility." While this might expedite certification of eligibility, it would not, of course, eliminate investigation of the applicant's financial status to evaluate the accuracy of the statements made under oath. It might in fact, subject the aged person to great legal hazard since an untrue or incomplete statement made through forgetfulness, senility, or illness and then sworn to, might be used in possible prosecution.

The consequences of family responsibility laws are quite serious—both in terms of the elderly individual, his relatives, and the relationship between the generations. These laws have encountered the natural reluctance of elderly persons to subject relatives to financial investigations and thereby deterred use of the MAA program by many for whom it was intended.

Some rather succinct comments on the effects of relative responsibility requirements were assembled by the Community Council of Greater New York. These were incorporated in that organization's testimony before a New York legislative committee (Metcalf committee) which conducted hearings on MAA in November 1962:

MARCH 8, 1961, LETTER FROM COMMUNITY COUNCIL TO THE HONORABLE NELSON A. ROCKEFELLER

* * * The elimination of relative responsibility would simplify the implementation of the bill. * * * In New York City less than 6 percent of persons over 65 years of age are receiving old age assistance. In many of these instances, the grant is supplemental to the contribution made by relatives. The Bureau of Census released information in January 1960 to the effect that the annual income of approximately 60 percent of individuals 65 years and over is less than $1,000. This includes persons having no income at all. In light of these facts, it can readily be seen that many older persons without adequate means are already being supported by relatives. Of considerable concern is the extent to which a financial burden has been placed on legally responsible relatives for aged parents in institutions for long-term care. In addition we urge consideration of the fact that many older people in need of medical care will not apply for medical assistance in order to avoid subjecting their children to an investigation of financial resources.

FEBRUARY 28, 1962, CENTRAL BUREAU FOR THE JEWISH AGED, STATEMENT OF THE OPERATION OF MAA

* * * Longevity has not been an unmixed blessing for the aging and their children. There are children who are themselves in the 60's forced to provide for parents in their 80's and 90's; an obligation which precludes any possibility of providing for their own old age, already upon them. Other children are caught by this necessity at a time when the costs of providing for their families are at their peak. They find themselves in a dilemma which forces a choice between providing normal opportunities of advancement for their own families and helping their parents. For example, 50 percent of income in excess of $5,000 for a family of four has to be made available for an aged person. Therefore, a man earning $6,500 will be called upon to contribute $750—more than 10 percent of his income—while at the same time he is attempting to raise and educate two children. Understandably, there is frequent rebellion on the part of the spouse and their

children against accepting deprivations resulting from such significant reduction of income. Insupportable tensions, anxieties, and frustrations result and family relations are frequently strained to the breaking point. * * *

JUNE 1962, DEPARTMENT OF PUBLIC AFFAIRS, COMMUNITY SERVICE SOCIETY, HEALTH CARE INSURANCE FOR THE AGED

* * * The society's caseworkers, public health nurses, and home economists witness the impact of acute, catastrophic, and long-term illness and its social and economic consequences in their everyday contacts with troubled families and individuals. An overwhelming proportion of the elderly are men and women who have worked faithfully and hard all their lives, and have tried to save for their old age. The fact or the prospect of illness and its cost is a persistent worry—frequently mentioned. When sickness comes and savings are gone, the aged fiercely resent applying for MAA and "going on welfare." Investigations and a means test are counted a public acknowledgement and a personal acceptance of failure after a lifetime of struggle to be independent. Often older people and their adult children prefer to go without necessities in order to "remain off welfare." This tends to put a severe strain on family relationships. Adult children, if young, have responsibilities to their own children; if older, are close to retirement themselves. From actual experience—from case records—comes the conviction that medical dependency is one of the common causes for serious family tension and disruption.

1961 HEALTH INFORMATION FOUNDATION, RESEARCH SERIES NO. 20, "FAMILY RELATIONSHIPS OF OLDER PEOPLE," ETHEL SHANAS

On the basis of a study of attitudes of 1,734 persons aged 65 and over and members of their families, Dr. Shanas stated: "What older people seem to want most from their children is love and affection. Apparently many older people feel that to ask their sons or daughters for financial help would threaten the affectional relationship between the generations."

MAY 1962 SOCIAL SECURITY BULLETIN, ALVIN L. SCHORR, "FILIAL RESPONSIBILITY AND THE AGING, OR BEYOND PLUCK AND LUCK"

Conclusions

To sum up: Filial responsibility laws cannot be considered alone, for they should have some rational relationship to the way families live. These laws do not represent the normal pattern of American family life, nor are they likely to be enforced except on public assistance families. In fact, a case for the repeal of these laws can be based solely on their effects on family relationships. (This was probably the primary motivation of the recommendations against support requirements made by the 1961 White House Conference on Aging.)

Support laws appear to be intimately related to vague, though powerful, fears about the deterioration of families. The anxiety may be real, but it is not tied to objective trends in family life.

Filial responsibility laws must also be considered in relation to poverty. The requirement to support is one of the network handicaps that surrounds a poor family; it may, on occasion, be the crucial handicap that persuades a person that improvement is not in the cards for him. Earlier in this article images and their dangers were discussed. Visions merit rather more respect. We have had the vision from time to time of so organizing public welfare, and our society, that we shall wipe out poverty as we know it today. Eliminating the support requirement in public assistance is only one element in this program, but it is an element.

Ten of the twenty-five States with MAA programs in operation have recovery programs extending to the homes of people receiving help and collectible after death. As was stated in the staff report of June 15, 1962:

> This committee's hearings have shown us that Americans now of retirement age equate "free and clear" ownership of one's home with self-respect. The idea of a State taking a claim on that home is completely unacceptable to them.

The widespread adamant and wholly natural refusal of the older individual to have the State hold a lien on his home for the amount paid in his behalf under MAA has a predictable effect. He refuses to apply for MAA help. He would literally rather go without any assistance than to run the risk of losing what is often the only tangible evidence of a lifetime of labor and struggle. This is just as true even though the lien may not be collected until after death. For the home is a personal symbol and the evidence of one's reality and achievement to be passed on to one's children.

It is manifest that Kerr-Mills is not the definitive answer to the problem of providing basic health protection to older Americans. Nonetheless it is an answer—even if only a partial one. Enactment of a program of hospital and related benefits under social security would in all probability, enable all States to properly implement Kerr-Mills. Kerr-Mills, along with private insurance, could be employed to supplement the "floor of protection" provided under the social security-based program.

IV. Evolution of Legislative Proposals To Afford a "Floor of Protection" Against Hospital and Related Expenses Through the Social Security System

The major health insurance proposals introduced during the period 1960 through 1962 tended to concentrate upon the needs of the elderly.

The social security-based proposals of 1960, in which coverage for hospitalization constituted the key benefit, were set aside and the Kerr-Mills program of medical assistance to the aged was enacted as a substitute.

In 1961 and 1962 bills proposed fell into three major categories: (*a*) health insurance benefits for social security beneficiaries through OASI; (*b*) Federal grants to States to provide health insurance to the aged with limited incomes; (*c*) credit against income tax for medical care insurance premiums.[16] The administration-supported King-Anderson bill (H.R. 4222 and S. 909) proposed to provide hospitalization, nursing home, and home health services, and outpatient diagnostic services, using the mechanism of social security for financing. Little difference of opinion occurred with respect to the types of benefits.

The major issue was social security financing. The McNamara bill (S. 65), the Javits bill (S. 2664) and the Lindsay bill (H.R. 11253) suggested adding general revenue financing for those elderly not eligible for social security benefits with some sharing of the costs by the States in the case of the Lindsay bill. The Bow bill (H.R. 10755) called for financing entirely from general revenues.

The King-Anderson bill (H.R. 4222) was introduced early in the first session. In the second session the Anderson bill, with the support of 25 other Senators, was introduced as an amendment to H.R. 10606, the public welfare bill, with certain major modifications: (*a*) Payment of health insurance benefits from general revenues for aged persons not eligible under OASI, (*b*) use of approved private nonprofit organizations in the administration of the program, and (*c*) an option under which beneficiaries could have their benefits financed through private plans rather than a Government agency. Several other amendments were approved on the floor of the Senate by the bill's sponsors including one by Senator Javits relating to an option to continue private health insurance protection.

A comprehensive discussion of the features and fate of the most recent proposals is contained in the following excerpt from an article by Wilbur J. Cohen and Robert M. Ball which appeared in the October 1962 issue of the Social Security Bulletin:

Proposals for Health Insurance for the Aged

ADMINISTRATION PROPOSAL

On February 9, 1961, President Kennedy transmitted to Congress his recommendations relating to a health program. To help meet the problem of financing the high cost of illness in old age, the President recommended the addition of a health insurance program to the present old-age, survivors, and disability insurance system.

Under his proposal as transmitted, all persons aged 65 and over who are eligible for old-age, survivors, and disability insurance or railroad retirement benefits would be entitled to (1) up to 90 days of inpatient hospital services in a single spell of illness, subject to a deductible amount (to be paid by the patient) of $10 a day for up to 9 days, with a minimum of $20; (2) up to 180 days of skilled nursing-home services after

[16] A committee print prepared by the Special Committee on Aging entitled, "Comparison of Health Insurance Proposals for Older Persons, 1961–62" charts the features of six bills.

discharge from a hospital; (3) hospital outpatient diagnostic services for all costs in excess of $20; and (4) visiting-nurse and related home-health services.

On February 13, a bill (H.R. 4222, the Health Insurance Benefits Act of 1961) proposing a program along the lines set forth by the President was introduced by Representative King, of California. (A companion bill, S. 909, was introduced in the Senate by Senator Anderson.) The House bill was referred to the Committee on Ways and Means, which held public hearings from July 24 through August 4, 1961. There was no further congressional action in 1961 on health insurance for the aged.

In both his state of the Union message of January 11, 1962, and his health message of February 27, President Kennedy renewed his 1961 request that the old-age, survivors, and disability provisions of the Social Security Act be amended to provide health insurance protection for the aged. On June 11, the House Ways and Means Committee went into executive session to consider the administration's proposal for a health insurance program for the aged under the Social Security Act.

SENATE FLOOR DEBATE

Anderson amendment

In the absence of action on the administration's proposal by the House of Representatives or the Senate Committee on Finance, Senator Anderson, on June 29, 1962, presented to the Senate for himself, 20 other Democratic Senators, and 5 Republican Senators an amendment intended to be proposed to H.R. 10606, the public welfare bill. Although the amendment provided the same health insurance benefits that would have been provided under S. 909 (except that skilled nursing-home benefits would have been payable only for services furnished in facilities affiliated with a hospital), the proposed amendment made several significant modifications designed to meet various objections raised to certain provisions of S. 909.

These major modifications included provision for (*a*) the payment of health insurance benefits financed from general revenues for aged persons not eligible for monthly cash benefits under the old-age, survivors, and disability insurance or railroad retirement systems; (*b*) the use of approved private organizations, selected by hospitals or the other providers of services, in the administration of the program; and (*c*) an option under which beneficiaries could receive the health benefits through private insurance, group practice, and other voluntary plans, instead of through the Government.

Persons entitled to health insurance benefits.—One frequent criticism of S. 909 had been that it did not provide protection for the uninsured aged. The Anderson amendment would have provided for this uninsured group of 2½ million aged persons the same health benefits that would have been provided for those insured under old-age, survivors, and

disability insurance and would have financed the protection for the uninsured from general revenues. Under the amendment, persons who reach age 65 before 1967 and who do not meet the regular insured-status requirements of the old-age, survivors, and disability insurance program would have been deemed insured for health insurance benefits only. The uninsured reaching age 65 after 1966 would have needed, to be deemed insured for health benefits, three quarters of coverage—with a minimum of six—for each year elapsing after 1964 and before reaching age 65.

The special insured-status requirements for health insurance would therefore have "washed out" in 1970 for women and 1972 for men, since in those years the number of quarters that would have been required to qualify for health benefits would have been the same as the number required under present law for cash benefits under old-age, survivors, and disability insurance. The effect of the special insured-status provision would have been to insure for practically everyone aged 65 or over protection under the program, since most jobs are now covered by the Social Security Act.

Use of private organizations in administering the program.—The amendment would have considerably broadened the opportunity for use of private organizations in the administration of the program. Groups of "providers," or associations of providers on behalf of their members, would have been permitted to designate a private organization of their own choice to receive provider bills for services and to pay these bills. In addition, such organizations could have been authorized—to the extent the Secretary considered it advantageous—to perform related functions, such as auditing provider records and assisting in the application of utilization safeguards. The Government would have provided advances of funds to such organizations for purposes of benefit payments and as a working fund for administrative expenses.

During their testimony before the Committee on Ways and Means on H.R. 4222, representatives of the American Hospital Association recommended that the Government use the services of voluntary organizations, such as Blue Cross, to administer the health insurance program. The principal advantage hospitals and other providers of services saw in an arrangement of this sort was that the policies and procedures of the Federal program would be applied by the same private organizations that administer the existing health insurance programs from which providers now receive payments.

It was believed that the participation of Blue Cross plans and similar third-party organizations offered possible advantages that go beyond the benefits derived from their experience in dealing with various types of providers of services. Having such private organizations serve as intermediaries between the Government and the providers would have helped to reduce anxiety on the part of providers of service and certain segments of the public about possible Government intervention in hospital practices.

Private insurance option.—A basic premise of S. 909 was that private insurance would play the same important complementary role that it has played in old-age, survivors, and disability insurance—that is, health insurance under the Social Security Act would be a base on which a beneficiary could build private supplementary protection. Many persons expressed the conviction that the health insurance proposal should have allowed beneficiaries to have all their protection with private insurance companies and health benefits plans instead of having Government protection or to continue any private insurance protection they may have acquired before attaining age 65 without changing it into a policy designed as a supplement to the Government protection.

The amendment included a provision under which an individual who had an approved private health plan or policy in effect for a period before reaching age 65—one furnishing at least all the benefits of the Government plan as well as some additional health benefits—could have an optional arrangement. He could, if he wished, have the Government reimburse the private organization with which he had the policy for the cost of the statutory benefits used. The carrier's administrative cost related to the payment of statutory benefits would have been included in the reimbursement.

The amendment would have required the beneficiary to make the election within 3 months after he became entitled to health insurance benefits. Only one such election would have been permitted, although a beneficiary could have later revoked his election if he desired.

To keep the administrative difficulties of dealing with private insurance carriers and health plans within reasonable limits the amendment also included criteria that private plans would have had to meet in order to qualify for handling the payments. Commercial nongroup carriers that are licensed in all 50 States and make at least 1 percent of all health insurance payments in the United States, or that were determined by the Secretary to be otherwise national in scope, would have qualified. A commercial nongroup carrier that could not meet these requirements would have qualified in a particular State if it did at least 5 percent of the health insurance business in that State. In addition, any other carrier that sells group health insurance would have qualified with respect to its group plans. Nonprofit plans would have been approved without regard to these requirements.

Additional modifications.—The Anderson amendment also modified or clarified certain provisions of S. 909 to give additional assurance that the Federal Government would not have exercised control over providers of services. An amendment provided that hospitals accredited by the Joint Commission on the Accreditation of Hospitals (and many small hospitals are not ordinarily accredited) would have been conclusively presumed to meet all the statutory requirements for participation, save that for utilization review. In the event

the Joint Commission adopted a requirement for utilization review, accredited hospitals would have been presumed to meet all the statutory conditions. In addition, the health and safety requirement was modified to permit the Secretary to prescribe further conditions only to the extent that these conditions were included in the requirements of the Joint Commission. Linking the conditions for participation to the requirements of the Joint Commission would have furnished assurance that providers would have been required to meet only professionally established conditions.

The provisions in S. 909 for a "hospital utilization committee" were replaced in the amendment by provisions for a "utilization review plan." A plan would have been required to provide for a review of admissions, length of stays, and the medical necessity for services furnished as well as the efficient use of services and facilities. The amendment specified that such review take place within 1 week following the 21st day of each period of continuous hospitalization and subsequently at such intervals as may have been specified in regulations. The utilization committee would also have been required to notify the attending physician of its findings and provide an opportunity for consultation between the committee and the physician. The utilization review plan of a hospital would have been extended to include review of admissions and length of stays in a skilled nursing facility affiliated with the hospital.

The Joint Commission, which has been considering adding utilization review as an accreditation requirement, has not decided what form the requirements should take. The utilization review requirement in the amendment therefore provided that both hospital staff reviews and other types of physician review arrangements outside the hospital would have been acceptable for purposes of the proposed program.

In addition, the amendment included several technical changes to take into account suggestions made by various professional organizations. The definition of the terms "drugs" and "biologicals," for example, was expanded to include those drugs listed in Accepted Dental Remedies and those approved by a drug or pharmacy committee of the hospital furnishing such drugs. The provisions relating to the definition of a "skilled nursing facility" were also revised to include only such a facility affiliated or under common control with a hospital. This more restrictive requirement was added to provide greater assurance that payments would have been made only to those skilled nursing facilities that have adequate medical supervision.

Financing.—The proposed amendment would have provided for an increase in the social security contribution rates of one-fourth of 1 percent for employers and for employees and four-tenths of 1 percent for the self-employed. (The latter rate would have been three-eighths of 1 percent under S. 909.) The taxable earnings base would have been increased from $4,800 to $5,200 ($5,000 under S. 909) a year. A sepa-

rate health insurance trust fund would have been established for the program; S. 909 would have provided for one social insurance trust fund with separate accounts for old-age and survivors benefits, disability benefits, and health insurance benefits, respectively.

Alternative proposals

On the floor of the Senate, three major alternatives to the health insurance program proposed in the Anderson amendment were debated. All the alternatives accepted the need for additional Federal action with respect to financing the health care costs of aged persons but proposed to meet this need either by providing Federal funds to States or by providing a cash supplement to monthly old-age and survivors insurance benefits to help meet the cost of private insurance premiums.

The Morton amendment.—Senator Morton proposed on July 5 an amendment under which States offering approved group insurance plans for the aged through private carriers would have received Federal reimbursement for the cost of the premiums paid on behalf of eligible aged persons. Anyone participating in the State program could have elected to receive either ordinary or catastrophic illness coverage. Group-practice, service, and indemnity-benefit private plans would all have been eligible to participate under State programs. It would have been necessary for State programs to receive the Secretary's approval.

General Federal revenues would have been used to reimburse the States for costs up to $125 a year per participant. States would have paid the administrative costs of the program, plus any premiums in excess of $125 per person. Individuals with a Federal income-tax liability would have paid up to $100 toward their own premiums; the exact amount would have been dependent upon the amount of the liability.

Senator Morton estimated the initial costs of his proposal at about $1.3 billion a year. Senator Anderson suggested that the cost of the Morton proposal could have run as high as $2 billion a year.

The Morton amendment was defeated by voice vote on July 6, 1962.

The Saltonstall amendment.—The amendment proposed by Senator Saltonstall on July 9, 1962, was essentially the same proposal as S. 937, the bill introduced on February 13, 1961, by Senator Javits for himself and eight other Republican Senators, including Senator Saltonstall. This amendment, like the Morton amendment, would not have used social security financing. It would have provided for a program of Federal matching grants to the States for health benefits for the aged, furnished under a State plan approved by the Secretary of Health, Education, and Welfare.

State plans would have been required to offer the aged individual a choice between three types of packages: (1)

short-term illness benefits covering up to 21 days of hospital services, up to 63 days of skilled nursing-home services (with substitution for hospital days permitted at a ratio of 3 to 1), up to 12 physician visits, outpatient diagnostic services, and up to 24 days of home health services; (2) long-term illness benefits with 80-percent coinsurance and a "deductible" of $175 for a maximum of 120 days of hospital care, surgical services, skilled nursing-home services, home health services, and certain other services at the option of the State; and (3) private insurance benefits, consisting of payment of half the premiums for a private health insurance policy, with the maximum payment amounting to $60 a year.

The Federal matching would have ranged from 33⅓ to 66⅔ percent. An individual whose income exceeded $3,000 and a married couple with income of more than $4,500 would have been required to pay enrollment fees related to income.

The Saltonstall amendment was defeated by a vote of 50 to 34 on July 12, 1962.

The Bush amendment.—On July 9, Senator Bush proposed an amendment under which reimbursement from social security trust funds would have been made to aged beneficiaries of old-age, survivors, and disability insurance for premiums paid for voluntary insurance. Beneficiaries would have been reimbursed, up to $9 a month, for the cost of premiums paid for any guaranteed renewable health insurance. To finance the program, the employer-employee contribution rate for old-age and survivors insurance purposes would have been increased 0.5 percent and the self-employed contribution rate, 0.375 percent. At $108 a year for 12.2 million beneficiaries—the number Senator Bush estimated would take advantage of the program—costs would be $1.3 billion in the initial year.

The Bush amendment was defeated on July 13, 1962, by a vote of 74 to 5.

Changes in Anderson amendment

During the course of debate on the Senate floor, several amendments to the Anderson amendment were proposed and either accepted by Senator Anderson or approved by a vote of the Senate.

On July 12, Senator Javits proposed an amendment designed to modify the provisions of the Anderson amendment relating to the beneficiaries' option to continue private health insurance protection. Under his proposal, an approved private plan could have provided, in place of the 90-day hospital benefit with a deductible, a 45-day hospital benefit with no deductible. Group insurance plans, prepayment group-practice plans, nonprofit plans, and plans having acquisition costs comparable to those of approved group plans would have been qualified to offer the option of either the 90-day hospital benefit or the 45-day hospital benefit. Other nongroup plans would have been permitted to offer only the 90-day hospital benefit. The amendment changed the period

during which a person would be required to have been covered by the approved plan from the 5 years that would eventually have been required under the Anderson amendment to only 1 year in group and nonprofit plans and 2 years in commercial individual policies. Senator Anderson accepted Senator Javits' proposal and modified his amendment accordingly.

An amendment proposed by Senator Carroll contained a declaration of congressional intent that enactment of a health insurance benefits program should not result in the loss of any benefits to which an individual may be entitled under a State medical care program. This amendment was approved by voice vote on July 13.

On July 16, a proposal by Senator McNamara to modify the "benefit period" provision of the Anderson amendment was accepted by Senator Anderson. A "benefit period" was defined as a period beginning with the first day covered services are furnished and ending with the 90th day thereafter (not necessarily consecutive) on each of which the beneficiary is not an inpatient in a hospital or skilled nursing facility.

On July 17, Senator Anderson also accepted a modification of his amendment proposed by Senator Muskie. Skilled nursing facilities that are not affiliated with a hospital would have been permitted to participate if the Secretary, on the basis of full and complete study, determined that they were equipped to provide good quality care and that their participation would not create an actuarial imbalance in the Federal health insurance trust fund.

On July 17, the Senate voted to table the proposed Anderson amendment. The vote was 52 to 48.

As the preceding section indicates, the latest proposal to provide hospital and related benefits under the social security system was thoroughly discussed and refined prior to the Senate vote on the amendment to the "welfare" act. From the closeness of the final vote it would appear that we had almost succeeded in our efforts to have the light cast by the facts herein recounted, pierce the miasma of confusion and doubletalk thrown up by the American Medical Association and its allies. It is our hope and expectation that this light will fully illumine the consideration given this problem by the 88th Congress and that this new Congress will enact the long-overdue program of hospital insurance through social security for America's older people.

Other Major Legislation Relating to the Provision of or Financing of Health Services for Older Persons Enacted During the Period 1960–62

1960

Public Law 86-778—Social Security Amendments of 1960.—Included among a number of significant changes in the Social Security Act made by this law were: (*a*) elimination of the minimum age of 50 as a qualifying requirement for disability benefits; (*b*) establishment under the public assistance provisions of a new program of

grants-in-aid to States for medical assistance for aged persons who are not recipients of old-age assistance but who have insufficient income or assets for necessary medical services (Kerr-Mills MAA); and (*c*) an increase in the extent of Federal sharing in vendor payments made for medical care rendered to recipients of old-age assistance.

Public Law 87-395—Community Health Services and Facilities Act of 1961.—This act provided formula grants to State health departments for the establishment and expansion of out-of-hospital community health services for the chronically ill and aged and provided for grants to State or other public and nonprofit agencies for demonstrations of new improved methods of providing health services outside of a hospital.

The Community Health Services and Facilities Act (sponsored by Senator Lister Hill and Representative Oren Harris) is one of the most forward-looking and significant laws benefiting older Americans that have been enacted in recent years. The President, in signing the bill on October 5, 1961, indicated, quite clearly, the importance of the Hill-Harris legislation:

> In my health message to Congress, I called for Federal action to help communities develop organized out-of-hospital health services and expand health care facilities, particularly for the care of the chronically ill and aged. The bill I have just signed—the Community Health Services and Facilities Act of 1961—is a strong, affirmative response by the Congress to this request.
>
> The bill authorizes special project grants to develop improved methods of providing out-of-hospital care so that many aged people and chronically ill patients can be spared the high cost of hospital care and can spend more time with their families. It authorizes increased Federal aid in the construction of health research facilities. It steps up support for research on the construction and equipment design of hospitals on a search for ways to improve services and cut costs. It encourages, by Federal grants, the construction of nursing homes to help relieve the existing shortage of these facilities. It will help place the best available knowledge in health care at the disposal of communities by increasing Federal assistance to State and local pubic health services.
>
> Effective public health measures and medical care depend, in the last analysis, on action at the community level. This legislation will provide stimulation for improvement in local organized heath services and facilities for home, nursing home, and hospital care, and particularly care for the aged. It will help to meet the objective of making quality health care available on an economical basis. I hope the State and community leaders and members of the health professions will take immediate advantage of the new opportunities provided by this legislation.

Public Law 87-31—Public Assistance Amendments.—This act increased Federal financial participation in medical care expenditures made in behalf of recipients of old-age assistance.

1962

Public Law 87-543—Public Welfare Amendments of 1962.—The amendments increased Federal financial participation from 50 to 75 percent for rehabilitative and social services for, among other public assistance categories, recipients of old-age assistance or medical assistance for the aged. In addition, they provided that such services might be made available to former applicants or recipients and to those likely to become applicants for old-age assistance or medical assistance for the aged.

Public Law 87-863—Increasing the maximum limitations on amounts tax deductible for medical and dental care.—Maximums on deductible medical and dental expenses for income tax purposes were raised for all taxpayers and to as much as $40,000 if the taxpayer and his spouse are ages 65 or over and are disabled. The chief beneficiaries of this legislation are those individuals who have high incomes with high medical expenses.

V. Dental Health of America's Aged

In their many discussions of the health needs of the aged, this committee and its predecessor subcommittee have focused attention on the major problem in this area—the financing of needed medical care. There is, however, another health problem confronting many of our elderly which, while it may not seem as pressing and while it calls for altogether different solutions, is nonetheless real and serious to those involved. That is the problem of dental health.[17]

The dental health needs of the Nation's elderly have only recently begun to receive the attention they deserve. Only 2.3 million of the millions of Americans over 65 years of age visit a dentist's office within a year, and virtually none are given dental care in their own homes or are cared for in institutions. This, despite the fact that, generally, the aged have more need for such care, and are more adversely affected by the lack of care, than any other population group. There are three major reasons for such neglect:

(1) The general physical condition of the aged.
(2) The immobility which characterizes current dental practice.
(3) The economic status of the aged.

The physical condition of the aged in relation to dental needs

The aged constitute the primary candidates for long-term illness or physical incapacity. Although the exact number of the chronically ill among the aged is not known, a study conducted by the commission on chronic illness in the city of Baltimore in 1956 indicated that persons over 65 had an average of four chronic diseases. These include various cardiovascular diseases, metabolic diseases such as diabetes and arthritis, emotional disorders, neuromuscular diseases, such as multiple sclerosis and Parkinson's disease, and malignancies. In addition, the aged commonly suffer from other long-term disabilities, such as those caused by accidents—for example, hip fracture.

[17] The committee would like to express its appreciation for the cooperation it has received in the preparation of this section from the Division of Dental Public Health of the U.S. Public Health Service and, in particular, from Dr. Stanley Lotzkar. We have drawn too on the scholarly and objective studies made in this area by the American Dental Association and others.

Of the chronically ill, approximately 450,000 are patients in nursing homes and small institutions, few of which have any dental facilities. About 1.2 million are homebound patients who cannot get around alone. They are therefore unable to seek routine dental services. The majority of the aged are ambulatory, but the very nature of the chronic conditions which afflict them makes it more difficult for them to seek care and more difficult, sometimes more hazardous, for the dentist to provide it.

Even for those among the aged who are not otherwise chronically ill, the presence of untreated dental conditions is serious; not only do dental diseases cause pain and disfigurement, but often, since they make it difficult for people to eat properly, they also lead to malnutrition.

It follows that the consequences of neglect for those who do suffer from chronic disease are even more serious, for pain and malnutrition deplete their energy and reduce their ability to cope with illness.

The immobility of current dental practice

In days past, dental equipment manufacturers concentrated on designing equipment which was fixed, immobile, and suited for only office treatment. As a result, the average practicing dentist was—and most still are—oriented to work only in his own office, providing care for people who can come to him. Even here, the average dentist usually lacks the flexibility which would permit him to care for patients suffering from chronic diseases such as tuberculosis, heart disease, diabetes, and mental illness. Not only does he not have suitable facilities, but his education has not equipped him for a more diversified practice. Only a handful of dentists even among those most recently graduated have had any opportunity to learn how to care for the institutionalized patient, the resident of a nursing home, or the bedfast patient in his own home.

Since World War II, however, excellent portable dental equipment has been on the market. It would be far too costly, of course, for individual practitioners to have on hand for the relatively few immobile patients each might treat. Consequently, until the equipment is made available locally—in all probability through local programs of public health dentistry in cooperation with local dental societies—until then it remains to all practical purposes unavailable to the public in need of it.

Under these circumstances, it is not surprising that dentists seldom participate in the planning of health care programs for the aged and chronically ill. In turn, their failure to participate means that most organized programs now in existence do not include dental care. For example, there are now some 50 programs designed to provide health services to the homebound. Not one of these offers dental care on an organized, continuing basis.[18]

The economic status of the aged in relation to dental needs

We have discussed this problem in detail above. Briefly restated in connection with dental health the economic problem of the aged is a compounding of two major factors. First, the aged usually have very limited financial resources. Half have incomes of less than

[18] Kurlander, Arnold B., "Actions on Home Care," in Guides To Action on Chronic Illness, New York, National Health Council, 1956.

$1,000 a year. Two out of every five people reported that if it were necessary for them to spend as much as $500 for medical care, they would have to mortgage their homes, borrow on life insurance, depend upon their children, or turn to charity.[19]

Second, at the point in their lives when they have the least money, the aged are in greatest need of health services. Their average medical bills are twice those of any other adult group. Therefore, in an effort to reduce costs, many older people neglect their dental health, even when they are physically able to undergo treatment.

The dental health status of the aged

That such large numbers of the aged consistently fail to see a dentist makes it extremely difficult to be specific about the extent of the need for dental treatment which exists among them. However, the records available on those who have independently sought care, together with data gathered through experimental programs and special surveys, make it clear that the dental health of the large majority of older citizens is appalling.

For example, an American Dental Association study of private dental patients revealed that for almost every type of dental treatment, the needs among those over 65 were greater than among any other age group. The one major exception to this pattern was in the need for fillings. Even here, when allowance is made for the great amount of toothlessness existing among them, the aged had a much more extensive backlog of need than should be allowed to exist. The study showed, further, that gum diseases are specially serious among the aged, since persons over 65 required three times as many extractions as other age groups because of these conditions. Their need for extractions for other reasons was 66 percent higher than that of other groups.[20]

The record is even worse among the institutionalized. Public Health Service examinations of nursing home patients revealed that 90 percent of them suffered from gum diseases and that some 44 percent required extractions.[21]

We are well aware of the difficulties encountered by State regulatory and standard-setting bodies in their attempts to insist that residents of nursing homes receive some continuity of medical care and we would be reluctant to suggest adding to their burdens. Yet these shocking figures obviously demand that something be done to resolve this problem. It is heartening to note that the American Dental Association and the U.S. Public Health Service are cooperating in their endeavors to find solutions to the problem. Once found—even tentatively—it is urgent that local dental organizations, nursing homes, and public bodies see to it that they are applied. Some programs suggestive of possible solutions are described below.

Often, the end result of long-term dental neglect is total loss of teeth. If the patient has the financial means, he can, of course, overcome much of the resulting disadvantage by wearing dentures. Un-

[19] Health Information Foundation Research Series 10, "Financial Resources of the Aging," New York, the foundation.
[20] "Survey of Needs for Dental Care," Bureau of Economic Research and Statistics, American Dental Association, 1954.
[21] U.S. Department of Health, Education, and Welfare, Public Health Service, "Dental Care for the Chronically Ill and Aged. A Community Experiment," Public Health Service Publication No. 899, U.S. Government Printing Office, Washington, D.C., 1961.

fortunately, total tooth loss is much more common among the elderly than are either the financial means or the availability of service for replacement. According to a study of dental fees conducted in 1959 by the Bureau of Economic Research and Statistics of the American Dental Association, the average cost of complete upper and lower dentures is $235.[22]

Among the nursing home patients mentioned above (and the same ratio holds true for the total over-65 population) 6 in 10 were found to be totally without natural teeth. At the same time, however, more than 3 in 10 of these same patients were in need of upper and lower dentures.[23] Yet, in the absence of care programs specifically designed and operated for the benefit of the aged and chronically ill, there is little likelihood that those in need of dentures or of other equally important dental services will ever receive them.

Current efforts to develop dental programs for the aged

In the past few years, interest in the dental health problems of the chronically ill and aged has steadily increased, and both governmental and nongovernmental agencies are today taking an active part in the search for practical solutions. Among the most important of the experimental programs and studies thus far undertaken are the seven described below.

(1) The Division of Dental Public Health and Resources of the U.S. Public Health Service has recently completed a study of the dental care of the chronically ill and aged in the metropolitan area of Kansas City, Mo. The 4-year study was an experiment in the development and administration of a prototype community program in which institutionalized or homebound patients were either brought to a central dental clinic or treated at home, as their conditions warranted. Portable dental equipment and special treatment techniques for the provision of dental services to homebound or institutionalized patients were developed.

The study proved that provision of home care services is feasible and that it actually requires only a minimum amount of additional training for the practicing dentist. Another significant finding was that where there are adequate transportation facilities, patients considered immobile can be brought to a dental clinic for treatment. Less than 10 percent of the patients required treatment at home.

The results of the study have been summarized and a brochure is presently available to assist planning groups in the organization of community dental care programs for the chronically ill and aged.[24]

(2) Another Public Health Service study was conducted in New York City in cooperation with the Beth Abraham Nursing Home and the home care program of Montefiore Hospital. The home care program at Montefiore Hospital was originally established in 1947 to demonstrate the feasibility of caring for indigent and medically indigent patients with long-term illness in their homes through an extension of hospital services. The purposes of the Public Health Service study was to obtain data and information on providing dental service to the patients in the home care program and in a large nursing home. The nursing home program involved over 400 long-term pa-

[22] American Dental Association, Bureau of Economic Research and Statistics, "Dental Fees in 1959," JADA, April 1961.
[23] Ibid., see footnote 21.
[24] Ibid., see footnote 21.

tients and the home care program nearly 100 patients. Care was provided in the clinic of the nursing home and in the patients' own homes. The results are now being evaluated.

(3) Methods of financing home dental care are currently being investigated as part of a cooperative project of the Public Health Service, the Western Reserve Dental School, and the Cleveland home care program. By the addition of dental care to an existing medical care program, the range of the program has been extended to include every medical and paramedical service.

The study hopes to determine what community, State or Federal resources can be made available for indigent or part-pay patients and to ascertain the relative number of patients who can afford fees which will adequately compensate the practicing dentist.

Private practitioners have been encouraged to provide home care dental services. For patients unable to pay, care is provided by supervised senior dental students.

(4) In accordance with a recommendation made by the American Dental Association, the Congress appropriated $300,000 to be used by the Division of Dental Public Health of the U.S. Public Health Service to demonstrate and stimulate the extension of dental services to handicapped children, the aged, homebound, and institutionalized persons. While these funds are limited and should be expanded, the Public Health Service has made an excellent beginning by initiating cooperative agreements with 12 schools of dentistry. Through these pilot studies, the most effective ways of teaching dental students the special skills and knowledge they need in caring for aged and chronically ill patients will be determined. Later, such training may become a standard part of undergraduate dental education. Programs are included in the following dental schools: New York University; University of Pennsylvania; Fairleigh Dickinson University; Tufts University; University of Pittsburgh; West Virginia University; Howard University; University of Tennessee; University of Alabama; Loyola University of New Orleans; Kansas City University; University of Washington, Seattle.

(5) The American Dental Association, supported by the American Public Health Association, is seeking Federal legislation to strengthen State public dental health programs by providing, in the existing program of grants-in-aid to State public health departments, a categorical appropriation for dental disease. In 1962, S. 917, sponsored by Senator Lister Hill, and designed to achieve that objective was favorably reported by the Senate Committee on Labor and Public Welfare but too late for floor consideration. H.R. 4742, sponsored by Congressman Oren Harris, chairman of the House Committee on Interstate and Foreign Commerce was a parallel bill. This committee hopes both measures will be reintroduced and acted upon favorably in the 1st session of the 88th Congress. Enactment of either of these measures would aid substantially in the development of State and local programs to facilitate the provision of dental services to the institutionalized and homebound aged. Important elements of such programs could be the acquisition of portable dental equipment and the training of dentists in the techniques of providing dental care to persons who, because of physical debility or other reasons, are unable to receive treatment under conventional methods.

(6) The American Dental Association has also been active in alerting its component societies to the needs of older citizens. Through its bureau of Economic Research and Statistics, a survey of needs for dental care was published in 1954.

As a result of recommendations of the Council on Hospital Dental Care, several hospitals with a majority of patients requiring long-term care or rehabilitation services have established dental departments. In May 1962, the American Dental Association issued a statement on the recommended dental care for patients in nursing homes. The American Nursing Home Association has distributed over 5,000 copies of this statement to its members.

(7) In the report of the National Conference of Nursing Homes and Homes for the Aged in February 1958, a recommendation was made pertaining to dental services for nursing home patients. Having concluded that comprehensive dental care has not been readily available to many residents of nursing homes, and that where care has been given it has been limited to emergency care for the relief of pain, the conference urged that more emphasis be given to the quality and quantity of dental care by these institutions. Toward this end, the conference recommended that dental evaluation of the patient on admission should be included in the patient's record. They also pointed to the need for a dentist to coordinate hospital health department and dental association participation in establishment of community programs.[25]

(8) Many other groups have also been giving attention to the dental problems of the aged. Several dental surveys of chronic disease care facilities have been completed by State and local health departments. The Joint Council To Improve the Health Care of the Aged, a group composed of representatives of the American Dental Association, American Hospital Association, American Medical Association, and the American Nursing Home Association, has helped to focus attention on the health needs of the aged and has presented dentists with an opportunity to act with purpose in helping to solve the chronic disease problem.

Suggestions for future action

Through the work which has already been accomplished by both governmental and nongovernmental agencies, a considerable body of knowledge has been assembled on the needs, methods of providing care, and organization of program for the care of the aged and chronically ill. Although there are still some problems and unanswered questions, the time has come when we must give the same high priority to the dental problems of the aged as we have given in the past to preventive dental services for the younger population.

It is now up to the dental profession to make plans to develop such programs at national, State, and local levels. Dental groups must see to it that plans for new programs include adequate dental care and that already existing programs add dental care to their list of services.

Organization of care programs will require changes in administrative procedures and basic orientation changes in dental practice.

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[25] U.S. Public Health Service, Division of Special Health Services, Chronic Disease Program Report; National Conference on Nursing Homes and Homes for the Aged; Washington, D.C., Feb. 25–28, 1958; Government Printing Office, Washington, D.C., 1958.

Dentists will have to be prepared to move out of their offices and into communitywide programs, trained and equipped to bring services where they are needed.

Education and training courses should therefore be expanded so that all dental schools reserve some portion of their curriculum for providing formal classroom instruction and clinical experience in the care of the aged and long-term chronically ill patient. Postgraduate and continuing education courses also should be made available for graduate dentists.

Further attention must also be given to methods of financing dental service for elderly patients. Major long-term illnesses usually cause a depletion of savings and family finances. Experimentation with methods of financing dental care are needed which will reimburse the dentist for his time and effort in rendering care during a time of economic stress.

And, finally, closer cooperation is needed between the medical profession, which is primarily concerned with development and organization of chronic disease programs, and the dental profession, which is primarily concerned with oral health problems. Supportive services must not be overlooked at a time when they are most important to the total health of the aged patient.

As the "Survey of Dentistry" has pointed out, however, dental public health agencies should take the leadership in the overall development of adequate dental care programs for the aged and chronically ill. This survey, prepared by an independent commission of outstanding dental and lay leaders, urges that dental public health agencies give impetus to more wide-scale action by instituting demonstration projects and experimental programs, by offering specific training in this field, by sponsoring inservice training and continuing or refresher education, and by conducting field and applied research and epidemiological surveys.[26] The Congress, on its part, should be prepared to extend expanded financial assistance to such greatly needed undertakings.

Activity is already underway in most of these areas. It must be intensified. In the meantime, groups in and out of Government must concentrate upon the full use of the knowledge already gained. The aged cannot forever wait upon the future for that dental care which is so essential to their health and well-being.

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[26] Commission on the Survey of Dentistry in the United States, "Survey of Dentistry, the Final Report," American Council on Education, Washington, D.C., 1961.

CHAPTER II. DEVELOPMENTS REGARDING EMPLOYMENT OF THE AGING AND INCOMES OF THE AGED

In this chapter of our report we shall devote most of our attention to the subject of the income levels at which our country's elderly attempt to live. We believe, however, that to properly understand and interpret that picture, it is necessary to know something of the employment problems which too often confront those Americans who, while they are not young, are certainly not yet aged. Therefore, we begin with a discussion of:

The Employment Problems of Older Workers [1]

In the context of health and welfare problems and services, the "older" person is usually thought of as a person at or beyond retirement age—generally speaking, 65 years of age or over. In the context of employment, however, the term "older workers" starts with those in the middle years—about 40 or 45 and older—and age barriers to employment sometimes occur at even earlier ages. Thus the person who becomes unemployed as he approaches or enters the middle years finds himself in an increasingly unfavorable position.

Arbitrary age barriers to employment result from the fact that employment practices have failed to accommodate themselves to profound population changes. While the increase in the number of persons 45 years of age and over [2] has far outstripped the growth rate for the population as a whole, and while life expectancy has increased, work-life expectancy has decreased. At the same time, society itself has created unnecessary obstacles to employment of older people, which have no factual basis or moral justification. A premium has always been placed on youth, due, no doubt, to the dynamic nature of our national development with its pioneering traditions. Unfavorable beliefs and generalizations about older persons have grown up and have been translated into restrictive policies and practices in hiring new employees which bar older jobseekers from employment principally because of age. Thus the unemployed older worker finds the greatest barriers to employment at an age when he has the greatest need for employment in order to house, support, and educate his children, and to accumulate assets for his retirement years. In addition, extended unemployment at this stage of his working life can mean reduced social security pension benefits upon retirement, thus creating additional future problems not only for the worker himself but for the economy and society in general.[3]

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[1] The committee would like to express its appreciation of the continuing and intelligent helpfulness extended it not only in the preparation of this chapter of its report but throughout the 2 years of its existence by Mr. Anthony J. Fantaci, Chief, Division of Special Worker Services of the Department of Labor's Bureau of Employment Security, and his staff.

[2] More than 55 million Americans are aged 45 or over.

[3] Appendix B illustrates the impact of various patterns of intermittent employment upon the retirement benefit afforded under the social security program.

The Department of Labor and the U.S. Employment Service, together with its affiliated State employment services, began giving special attention to the older worker problem in the 1940's. To determine the nature and extent of this problem, limited studies and surveys were conducted in 1950 and 1954 by State employment security agencies in cooperation with the Bureau of Employment Security of the U.S. Department of Labor. The 1954 study showed that older workers were not being placed in job vacancies registered with USES offices in proportion to the numbers of such jobseekers. As a result of the facts brought to light by the 1950 studies, the Secretary of Labor in April 1954 appointed a Departmental Committee on Older Workers to develop recommendations for a program to reduce artificial age barriers to employment opportunities. Although there was strong indication in the earlier studies that job placement of older workers could be increased by giving them intensive assistance, there were many questions left unanswered.

With funds authorized by the Congress in July 1955, the Department of Labor undertook a comprehensive research program to explore what appeared to be the major difficulties or roadblocks to increased employment opportunities for older workers. A major undertaking of the research program was a survey of the labor market experience and problems of older workers conducted by the U.S. Employment Service and affiliated State employment services in seven major labor markets. This survey came to be known as the Seven Cities Study.[4]

The Seven Cities Study brought to light and clearly pointed out that older workers, particularly those in the 45-and-over age bracket, faced imposing obstacles in employment once they became idle, and that specialized, more intensified services were required to assist them in obtaining reemployment. The survey highlighted the fact that the greatest single obstacle facing the unemployed older worker was arbitrary age limits set by employers in their hiring practices—for example, sometimes even as low as under 35 for clerical positions, and in many cases, under 45. Of the 21,386 job openings filed in April 1956, in employment service offices in these seven cities, more than one-half specified maximum hiring ages of 55, more than two-fifths specified under 45, and one-fifth under 35.

The study also revealed that the older worker faced the additional obstacle of meeting educational requirements, such as possession of a high school diploma, which he had had less of an opportunity to secure than his younger competitor for a job. And, even where he had the educational qualifications, he sometimes met with the additional problem of meeting rigid physical requirements which may or may not have been related to the job to be done. He often faced a lack of training and retraining facilities which would enable him to better prepare to meet the requirements of actual or potential job opportunities. Finally, in addition to these external obstacles, other problems, stemming from his own experience and background, often constituted further barriers to employment. For example, if he had

[4] The overall findings of the research program were formulated and presented in the following documents published by the Department of Labor:

1. "Job Performance and Age: A Study in Measurement."
2. "Older Worker Adjustment to Labor Market Practices: An Analysis of Experience in Seven Major Labor Markets."
3. "Counseling and Placement Services for Older Workers."
4. "Pension Costs in Relation to the Hiring of Older Workers."
5. "Older Workers Under Collective Bargaining, Parts I and II."

worked for one employer for a long time, he often had forgotten how to look for work. Or he might fear the change and adjustment he would have to make. Or he might lack realization of his own limitations and of local labor market conditions and make unrealistic wage demands. Finally, because of his long attachment to his community he tended to restrict the geographic area of his search for employment.

It is an anomaly that this bias and prejudice against the older worker do not appear while he is employed. Various surveys have shown that the employed older worker is highly regarded by his employer for his reliability, production, and attendance, but once he is unemployed such assets are not considered by prospective employers. The stereotypes of inflexibility, lowered productivity, physical decline, and other negative characteristics are attributed to him. Studies by the Department of Labor, the National Association of Manufacturers, the U.S. Chamber of Commerce, and other public and private agencies have exploded these myths, but bias and prejudice persist long after the facts are brought to light.

Many employers indicated that hiring older workers would increase their pension costs and justified their rejection of the older applicant for this reason. However, the Department of Labor's "Pension Costs in Relation to the Hiring of Older Workers," prepared with the assistance of a citizens' committee comprised of pension consultants, bank trust officers, educators, and life insurance companies reached this conclusion: "The costs of private pension provisions ought no longer to be considered a real obstacle to the employment of older workers." The National Association of Manufacturers in a recently published brochure, "The Productive Years—Age 45–64" came to a similar conclusion:

> The more one examines pensions and insurance costs, the less valid they become as legitimate barriers to the employment of mature workers. When one considers the many personal assets the mature worker brings to the job, pension and insurance costs certainly lose whatever significance they may appear to have.

The salient fact concerning the employment problem facing the older worker is that it does not arise from a high unemployment rate of the 45-and-older worker in the labor force. The unemployment rate for the 45-and-over worker has consistently been lower than the rate for the 24–44 segment of the labor force. Rather, the employment problems facing the older worker stem from the fact that once unemployed he experiences far greater difficulty in securing a new job than does the younger worker. The percent of the 45-plus workers unemployed 27 weeks or more has always exceeded that for the 25–44 group.

As a result of the Seven Cities Study, the Department of Labor, and particularly the U.S. Employment Service, launched a national program of expanded and improved services to older workers in 1958. The program comprised a three-pronged attack on the problems of age discrimination in employment as follows:

> (1) Direct service programs to provide placement, job counseling, and job development assistance in finding suitable employment. Among the steps taken to effect improved services were

the designation of State older worker specialists in all State employment services, the designation of full-time or part-time older worker specialists in each local employment service office, the development of extensive training materials, and the actual training of employment service staff to work more effectively with older workers.

(2) Educational and informational programs aimed at changing negative attitudes, correcting misconceptions, and eliminating bias in employment of older workers. In addition to actively participating in conferences and other activities of an informational and educational nature, the Department of Labor developed numerous informational materials which were widely disseminated and used.

(3) Research studies to develop economic and social facts about the capabilities and characteristics of older workers. These included studies of productivity, and of the effect of age on specific aptitudes, such as numerical, spatial, manipulative ability, etc., which would have a bearing on trainability for other jobs.

In addition to these developments, State legislation of various types was enacted, varying from laws which make it illegal to discriminate in employment because of age, to laws which establish commissions or other bodies to advise on the gamut of problems affecting older persons, including the employment of older workers. Prior to 1959, six States, Colorado, Louisiana, Massachusetts, New York, Pennsylvania, and Rhode Island had enacted laws relating to the employment of older workers.

Federal policy on employment of older workers

From 1927 to 1942, a standard maximum hiring age limit of 53 was established by the Civil Service Commission. During World War II, to meet employment demands, age limits were lifted for most positions. In 1946, with the end of the emergency, age limits were reinstated for open competitive examinations, with the maximum age limit set at 62.

The first law dealing specifically with maximum age limitations for entrance into the Federal service was enacted by the Congress in 1952. Further legislation was enacted in 1955. The permanent legislation currently in effect was enacted by the Congress in 1956 (sec. 302 of Public Law 623) which provides:

> No part of any appropriation hereafter contained in this or any other Act shall be used to pay the compensation of any officers or employees who establish a requirement of maximum age for entrance into positions in the competitive civil service: *Provided*, That no person who has reached his seventieth birthday shall be appointed in the competitive civil service on other than a temporary basis.

The Civil Service Commission, in accordance with the above enactment, sets no maximum age limits for positions in the Federal competitive service. The Commission has established standards for Federal jobs in terms of ability and qualifications of individuals to perform the work, regardless of age. Persons are placed on civil service registers solely on the basis of merit and fitness (taking into consideration veterans preference). These policies apply to the com-

petitive civil service, which covers about 90 percent of all Federal employment. A survey of employees, covered by the Civil Service Commission's Retirement Act, as of September 1958, revealed that 56 percent were 40 years and over, 27 percent were 50 and over, and 9 percent were 60 and over.[5]

Developments since 1959

Any program aimed at the reduction or elimination of bias and prejudice must of necessity be a long-range, continuing one. Undesirable and unfair attitudes, developed over a lifetime and often not consciously recognized as bias or prejudice by those who have them, are not easily changed, and any attempt to accomplish change must utilize every possible rational approach. The findings of the Seven Cities Study have played a definite role in stimulating efforts by National, State, and local groups, both public and private, to provide equal opportunity for employment for older workers based upon their qualifications without regard to age.

That the problem continues to be a serious one, however, is attested to by the fact that while in September 1959 there were 953,000 unemployed workers 45 years of age and older, by September 1962 the number had increased to 1,036,000. At least as significant as the increase in the number unemployed is the fact that in September 1962 over 42 percent of the male 45-and-over workers were unemployed 15 weeks or more, with 25 percent being unemployed 27 weeks or more. In other words, in September 1962, one out of four unemployed male workers 45 years and over were unemployed for more than a half year. By comparison, of unemployed men 25 to 44 years of age, only 26 percent had been unemployed 15 weeks or more, and 16 percent 27 weeks or more.

Within the Department of Labor, perhaps the most significant development was the overall Employment Service expansion and improvement program in 1961. The effect of this expansion and the resulting increased services to older workers is evident in the statistics for fiscal year 1962. During that year, placements of workers 45 years of age and over exceeded 1¼ million—the highest number since the inception of the older worker reporting program in July 1957. Counseling services for older workers during that year also reached an alltime high. Continuing emphasis was given by State agencies to cooperative efforts with other interested community agencies in setting up specialized training courses for older workers and in the development of programs through which older workers could more effectively help themselves in solving their employment problems. California provides a notable example of such activities, including:

(1) *Experience unlimited.*—This group, organized by Employment Service staff, provides an opportunity for jobless executive and managerial personnel to discuss their mutual job-related problems and to help each other find suitable jobs.

(2) *Career associates.*—This is the feminine counterpart of experience unlimited.

[5] Appendix C contains tables indicating the number of employees and percent of total employment represented by different age groups in the major Federal agencies as of June 30, 1962. Similar data is also presented in terms of new employees hired by such agencies during the period Jan. 1. 1959, to June 30. 1962.

(3) *Maintenance gardeners.*—Middle-aged men with varied occupational backgrounds learn a satisfying new occupation. The special course of instruction includes techniques of soil care, planting, pruning, weed control, and safety factors. It is taught through regular adult education facilities.

(4) *Homemaker, home manager.*—This program was developed to utilize the abilities and experience of middle-aged women from the business, teaching, and social work fields in connection with the problems of the elderly "housebound." The women are given specialized training, and assume certain responsibilities on a part-time basis. They are not domestics. This program was given the State merit award of the International Association of Personnel in Employment Security in 1960.

(5) *Senior home repairers.*—A program tailored to supplement social security income. A pool of men from the skilled trades over 65 years of age, who have their own tools, do simple home repairs. They do not wish full-time work.

(6) *Senior research associates.*—A group of retired professional men make their services available on a consultant basis to small businesses and individuals who otherwise would not be able to afford such services.

The White House Conference on Aging, held in January 1961, gave further impetus to the development of programs aimed at improving employment opportunities for the older worker. It reflected the growing national awareness of and desire to do something effective to meet the problems of the older worker in our labor force. The Department of Labor worked closely with the staff of the Conference in developing plans and activities. The State employment services took a prominent role in State committees or commissions on aging in planning and conducting State and local conferences in preparation for the White House Conference.

The recommendations of the conference constituted, in effect, both a positive endorsement of the program of the Department of Labor and its affiliated State employment services for serving older workers, and the identification of certain deficiencies in these services. The conference recommended expansion of the Federal-State program of the Department of Labor with respect to (1) providing needed counseling and placement services to older workers, (2) increasing employment opportunities for over-45 persons, (3) gathering facts about the nature, extent, and effects of upper-age restrictions in hiring, and (4) promoting understanding and support of increased earning opportunities for older persons.

A further significant development since 1959 was the increase in the number of States that have enacted age antidiscrimination employment laws. As stated previously, six States prior to 1959 had enacted such laws. From 1959 to date nine additional States (Alaska, California, Connecticut, Delaware, New Jersey, Ohio, Oregon, Washington, and Wisconsin) and the Commonwealth of Puerto Rico have enacted similar legislation.[6]

[6] S. 1166, sponsored in 1961 by Senators McNamara, Clark, and Randolph would prohibit discrimination in employment for reasons of age by Federal Government contractors and subcontractors. It is hoped that this legislation will be reintroduced and acted upon by the 88th Cong.

An informal survey conducted in January 1960 by State employment security agencies in seven States having age antidiscrimination legislation revealed the following: (1) Relatively few complaints have been filed by workers; (2) employer reaction varies from indifference to active cooperation; (3) a feeling of general improvement was noted in the climate of acceptance of older workers for job openings; (4) the law serves as an expression of public policy and morality; (5) virtual elimination of age requirements in newspaper ads resulted; and (6) the need for reinforcing the laws with educational programs was recognized, with one State expressing the opinion that legislation hastened the educational process.

A major development in the past decade has been a marked increase in women's participation in the labor force. Women are expected to constitute almost half of the total increase in the Nation's labor force in the 1960–70 decade. Because the rise was confined to married, widowed, and divorced women, and was sharpest among women in the 45 to 64 age group, older women now constitute more than a third of the older worker total. They encounter additional problems when faced with job loss, since age limitations on hiring are often more restrictive for them than for men. The Women's Bureau of the Department of Labor, in cooperation with the State employment services, has developed, promoted, and helped to plan a series of earning opportunities forums in 32 cities with over 10,000 individuals attending the forums. These forums focused communitywide attention on jobs that can be filled by qualified older persons. At first planned for women only, the program was expanded in the later forums to include both men and women.

In addition, both public and private organizations have been carrying on programs relating to or promoting employment of older workers. Universities are engaged in a variety of research projects covering problems of employment, preretirement and postretirement, and income maintenance.

The Council of State Governments conducted a series of regional conferences throughout the country to inform State legislators and officials about the aging problem with special attention given to the employment problems of the older worker.

The American Legion has set up a program of awards and citation for employers to encourage employment and retention of older workers; has set the first full week of May as National Employ the Older Worker Week for the American Legion. The Fraternal Order of Eagles has initiated a "jobs after 40" campaign; advocating Federal and State anti-age-discrimination legislation.

The National Council on the Aging has a section on employment of the older worker and sponsors research and serves as a clearinghouse on information in this field.

The National Association of Manufacturers has conducted an active educational program directed at its employer membership and the general public on the advisability of hiring on the basis of ability without regard to age. The American Medical Association has held numerous regional meetings on aging, devoting a portion of each one to the subject of employment of the older worker.

The interest of private agencies in the older worker problem is exemplified by a Ford Foundation grant in 1961 to Washington University (St. Louis) and the University of Illinois. This research project has two purposes. The first is to analyze those placement programs for jobseeking middle-aged and older workers established by the public employment service and by other public, semipublic, and private agencies involved in placement. The second is to develop recommendations for appropriate changes in public policies and in the programs, practices, and internal procedures of employment agencies that will help strengthen the job placement of older workers on an equal opportunity basis. Arrangements for community studies in six States were begun in November 1961 and it is anticipated that the gathering of data will be completed in the spring of 1963. Between the fall of 1963 and the spring of 1964, it is contemplated that several conferences will be held to present the results of the studies to the representatives of public and private employment agencies.

Areas of concern and current or proposed action

(1) *Impact of automation.*—The impact of automation on our economy and the threat of employee displacement by automation is of deep concern to the Nation. Authorities agree that no yardstick exists which defines with any degree of precision the exact effect on employment. No way has yet been found to exactly equate automation and unemployment. The fundamental question as to the impact of automation on our labor force relates to such factors as which jobs will be eliminated, which jobs will be created, where will these jobs be located, and which segments of the labor force will be affected.

There is unanimity of opinion that the four segments of our labor force most likely to be affected will be: the unskilled and semiskilled, the uneducated, the Negro, and the older worker.

The dilemma facing the older worker was summarized by Harold L. Sheppard, Louis A. Ferman, and Seymour Faber in their study, "Too Old to Work—Too Young to Retire: A Case Study of a Permanent Plant Shutdown.": [7]

> Putting it bluntly, when a factory—for whatever reason—permanently removes large numbers from its payroll, what shall be done for such employees? Classical economics to the contrary, such questions do not automatically take care of themselves. And it is somewhat frivolous, in our opinion to shed responsibility by resorting to arguments about the moral need of the individual unemployed worker's responsibility to fend for himself. The dilemma is compounded when such employees are defined as "old" when they are forced to reenter the labor market at a time when other, younger workers are also in the scramble for scarce jobs during a mass recession. The barriers to employment for older workers are formidable enough during high employment periods—these are based in a large part on the stereotypes and prejudices concerning older worker performance on the job, and sometimes on the fears of greater costs of

[7] Published by the U.S. Senate Special Committee on Unemployment Problems, Dec. 21, 1959.

hiring older workers among those employers with certain types of inadequately structured pension plans.

Summarizing, the impact of automation will not materially change or alter the basic nature of the employment problems facing the unemployed older worker. However, the problems will be intensified if the impact of automation results in the increase in unemployment of the older worker.

The Department of Labor is at present conducting studies concerning the characteristics and job-finding problems of workers already displaced by technological changes and in determining what measures may be taken to forestall or minimize unemployment attributable to this cause. Among the characteristics considered in both types of studies is the age factor.

In process is another study, which among other avenues of investigation, examines the older worker's adjustment to changes in and transfer to production occupations. A number of demonstration projects, directed toward the long-term unemployed with obsolete skills are now being planned by the U.S. Employment Service. A considerable proportion of this worker group will be in the upper age categories. These projects will center on intensive counseling and placement efforts, including referral to training, as a means toward helping these workers to become employed.

(2) *Vocational training of older workers.*—It has often been alleged that substantial numbers of workers 45 and older, when given vocational aptitude tests to qualify for vocational training, show no aptitude at all, or disproportionately less aptitude than their younger counterparts. A study by the U.S. Employment Service, which is to be published in the February 1963 issue of the Personnel and Guidance Journal, refutes these allegations. The evidence offered in the study warrants the conclusion that when the factor of educational level is constant, there is no significant differences in levels of general intelligence, verbal, or numerical aptitude, between the average older, and the average younger worker, insofar as those factors are measured by aptitude tests. It is true, of course, that among workers in any age group, particularly among those with very little or no schooling, there will be some with very limited ability to deal with symbols, as these tests require. Therefore, low levels of performance in tests of intelligence, verbal, and numerical aptitude relate more closely to educational deficiencies than to age. On the other hand, the tests do show that there are some age-related decreases in certain other aptitudes, some slight and others more substantial. However, the study warns that even where the average decreases are substantial "many older individuals score higher than many younger individuals," and that such general statistics have no meaning when applied to individuals.

Not only do older workers possess necessary aptitudes for training but all available evidence indicates that the older worker can be retrained in many worthwhile occupations. The Bureau of Labor Statistics has compiled the results of a survey of the experience of several large employers in aircraft manufacturing, air transport, and oil refining, and of a smaller study of telephone operators, in retraining employees to perform new technical functions. Some 2,000 of the employees of these firms, who had completed training courses

ranging from a few weeks to 2-years duration, were divided about equally, into "over 45" and "under 45" age groups, which were compared as to course performance. The results, by and large, indicate that the younger trainees responded more readily and learned more quickly than the older group, when the courses were short and emphasized the rapid acquisition of perceptual-motor and comparable skills. The older trainees, on the other hand, did well in relatively complex and difficult courses that were continued long enough to give them time and opportunity for real study; that is, those requiring intelligence, and verbal and numerical ability. In a number of courses, the average older employee actually outperformed the average younger employee, and there were relatively few cases in which at least 40 percent of the older trainees did not exceed the general average for the course.

The passage of the Area Redevelopment Act, the Manpower Development and Training Act, and the Trade Expansion Act provide training opportunities to the older workers heretofore unavailable to him—opportunities to learn skills needed in our economy that can enable them once more to take their places in our economic society.

Experience to date suggests that there are problems concerning older worker participation in the training programs. There is need to examine the reasons why some older workers are not taking advantage of the training opportunities. New or improved techniques may be needed to motivate more older workers, who can profit from such training, to participate in these programs.

(3) *Use of employer-labor institute.*—As a principal means of combating age bias in employment, the Employment Service is encouraging the holding of employer-labor institutes sponsored by colleges, universities, or community groups. A leader's guide, "Meeting the Manpower Challenge of the Sixties With 40-Plus Workers," has been developed by the U.S. Employment Service to assist local committees on aging, universities, employer and labor groups, and other organizations concerned to focus attention on the local older worker problem and to stimulate positive action in regard to the hiring and utilization of this group. Such locally sponsored institutes are particularly well suited to achieve these objectives because they directly, and personally, involve those individuals who influence hiring policy and practice.

(4) *Employment problems of the 65 and over unemployed.*—An area that will require increasing attention is that of the employment problems of the more advanced age group of the 65 and over. Startling though it may seem, today many people in their sixties are supporting dependent parents. Many of this age group need and must work to supplement income from social security or private pension plans. Many drop out of the labor market because they find they cannot effectively compete for the available jobs. Others are seeking part-time work which will enable them to supplement their social security benefits. Still others must necessarily, because of health or other reasons, stipulate limitations of travel and conditions of work, thus restricting their job opportunities. More of these workers must become aware of and seek the aid and assistance of the public employment offices.

To assist this older group, the Department of Labor and affiliated State employment services are planning to conduct studies in several employment offices to analyze the special job problems of this group and to develop methods for distinguishing those older jobseekers requiring remunerative jobs from those requiring other services.

Since older people are doing so well in the Peace Corps, it is believed that enrollment in the proposed National Service Corps may have specific appeal to our senior citizens. The proposed Corps would enroll individuals of all ages and thereby provide our senior citizens with an opportunity to engage in activities in such fields as education, recreation, health, and conservation that are not only remunerative and interesting to them but helpful to their communities and the Nation.

The senior service corps, organized by the Michigan Commission on Aging, while limited to older citizens only, is an example of how our senior citizens can be productively utilized in the type of program embodied in the proposed National Service Corps. The objective of the corps is to provide some part-time employment and volunteer activities for senior citizens and thereby accomplish many of the tasks which go undone in our communities.

(5) *Need for community organization.*—There is need for the development of an overall manpower structure in the community to identify and interpret the problems of special groups as they relate to the economic health and welfare of the total community. Through such councils or committees the problem of all groups can be considered and more attention and effort can be placed upon a positive program directed toward a more intelligent use of the community's total manpower resources. The Department of Labor, through its U.S. Employment Service and affiliated local employment service offices has stimulated the formation of community advisory committees for dealing with employment problems of special groups. These advisory committees could easily form the nucleus of a more comprehensive advisory group concerned with the total problem of manpower utilization in the total community.

Progress will depend on the extent to which needed resources are developed and made available, as well as upon the cooperation of all agencies, public and private, National, State, and local, who are concerned with the employment problems of older workers.

Incomes of the Aging

The 4 years have witnessed a slow but steady improvement in the income position of the aged—an improvement that is evident even when allowance is made for price rises. But despite this continuing improvement, half of all persons aged 65 and older still have less than $1,000 in total cash income annually. The great majority can count on little regular income in addition to their social security benefits. For most, the home they own is the only significant asset.

That "some have adequate income; most do not" is as equally true today as in 1959 when stated by the opening witness at the first hearing of the Senate Subcommittee on Problems of the Aged and Aging.[8]

[8] "The Aged and Aging in the United States," hearings before the Subcommittee on Problems of the Aged and Aging of the Committee on Labor and Public Welfare, 86th Cong., 1st sess., pt. I, June 16, 17, and 18, 1959, p. 6.

These facts, which have been documented repeatedly in reports of this committee and of its predecessor, the Senate subcommittee, are summarized in chapter I, pages 10 to 14 of this report.

A wealth of supporting evidence has also been provided by the foremost experts of the country, both within the Federal Government and in nongovernmental positions, through the Washington hearings of the Subcommittee on Retirement Income in July 1961 and through our field hearings across the country.

Even more important, the committee's field hearings added a new dimension—a perspective in depth—to our knowledge about the income position of older people. It is one thing to know that, as a group, aged people have low incomes. It is quite another to hear from their own lips of their struggles to maintain themselves in a self-respecting and decent manner on these incomes.

The statistics now have faces and voices to go with them. Here are a few examples of their stories in their own words:

> My name is _____ and I live in the southeastern part of Pocatello, and I come here to express my own opinions about myself and my family. Now, I receive social security. My wife and I receive $123 a month social security.
>
> I am not asking for any help of any kind as long as I don't need it, but in the last 2 years I have fallen into some hardship. Two years ago I had to have an operation, which cost me $365. A year from that time, last October, my wife had to have an operation for cancer, which cost me $1,125. Now, I am trying to meet my obligations, but it's a hard matter. Here is my account. I have to pay $10 a month to the doctor, $10 a month on the hospital bill, $17 a month for fuel for my house to keep us warm. My electric bill runs $10 a month, and a repair on my furnace, which broke down, costs me $10 a month; that cost me pretty close to $60, and I am paying $10 a month on that. Then I have had a few repairs to do on my house which costs me another $10 a month. Then I have my taxes to pay, which costs me $120 a year for my home, and I pay $10 a month on that, and then I have taxes to pay for a new sewage system that they laid in my street where I live, and that cost me $10. Then I have a water bill to pay of $5 a month, and then I have another little bill here where I finally took out some insurance with Mutual of Omaha, and that costs me $8.50. Now, my total is $100.50 a month, and so I have $23 a month for my wife and I to live on. I'd like to know if any of you have to get down that low.
>
> I am not asking for any big support. My wife only gets $33 per month pension, and I get $90. She gets $33.80. Why she can't get any more, I do not see. She is disabled. I think she ought to be entitled to half of what I am getting, and why she can't get any more is above me, unless she took out her pension at 62. Maybe she would if her work had continued until she was 65, but I don't know. It is a kind of a hardship.

Then, on the other hand, I have heard a lot of talk today about aged homes, both pro and con. I don't think that we need so many homes for our elderly people. I have a home where my wife and I live in. We don't want to go into a rest home if we can make it in our home, and I think that our social security ought to give us enough so that we could. Two years ago, we got a $7 raise, between my wife and I, across the slate. What that amounted to was to take care of the high cost of living. I am paying on the same cost of living as the man who makes a hundred dollars a week. I have to pay the same prices he has to pay with my little income.

Another senior citizen writes in order to tell his story in detail, apologizing for the length of his letter by saying—

I don't know how I could explain our problem in fewer words and still be able to explain the cause of our present circumstances:

I note by the St. Petersburg Times that the Subcommittee on Retirement Income is having a regional conference on Monday, October 9, and that senior citizens having problems should contact you.

We have a problem.

I am retired, 69 years old, and receive social security benefits for my wife and self amounting to $168.40 per month. This is our only income.

I have paid into social security since its inception, and while working have held very good administrative positions and earned substantial salaries.

My wife's mother lived with us for 37 years and she had no other relatives. I was her only means of support.

On two different occasions she fractured her right and left hips and on several occasions lacerated her head—all of which required hospitalization.

The hospital, doctors, and nursing home expenses were enormous.

She was in a nursing home for approximately 1 year and a half at $75 per week.

She fractured her right hip while she was in a nursing home.

She was in the hospital for 3 months and while there she passed away at the age of 90.

In spite of the foregoing and other expenses we had a nice savings account.

April 1957.—My wife suffered a cerebral hemorrhage which paralyzed her left side. However she partially recovered with the exception of a slight drag with her left foot and only partial control of her left hand and arm.

The hemorrhage occurred while her mother was in the nursing home.

September 1957.—The manufacturing and service plant in Springfield, Mass. of which I was general manager was taken over by the parent company and I was retired.

The group hospitalization ended with my retirement.

My wife's doctor said my wife would feel better if we lived in Florida.

July 1958.—We came to Florida to look for a house and while in West Palm Beach my wife fell and fractured a vertebra and her left wrist.

Two days after my wife came out of the hospital I was admitted with a ruptured appendix.

As we were staying at a motel there was no one to take care of my wife, therefore we had to get her into a nursing home for 2 weeks while I was in the hospital.

After I was discharged we stayed another 2 weeks at the motel to recuperate, and then headed for the sun coast and we put a downpayment on a house in Orange Lake Village, Largo.

We returned to Florida and took possession of our home on December 1, 1958, November 4, 1959, my wife fell and fractured her left hip.

After two operations and 3 weeks in the hospital the fracture would not heal, therefore she had to stay in bed for 2 months, necessitating the hiring of a hospital bed, wheelchair, and walker.

At the present time she is mostly in bed; however, she can walk some with assistance.

December 25, 1959.—Christmas morning 1:15 a.m. I was admitted to the hospital with a bleeding ulcer.

It was again necessary to get my wife into a nursing home (for 2 weeks) as there was no one to take care of her.

April 1961 we traded our home in Orange Lake Village for a smaller and cheaper home in Florida Retirement Village.

Our monthly payments are much less and as I have to do all the chores including nursemaid etc., it's much easier for me.

May 4, 1961.—I was again admitted to the Sun Coast Hospital with a bleeding ulcer. While I was in the hospital my wife was admitted with stoppage of the bowels.

The doctor's, hospital, nursing home, and medication bills caused by the foregoing has reduced our savings to $10, and we still owe the doctor $20 and the hospital $69.

Our average monthly expenses are as follows:

House payments [1]	$50.59
Insurance [1]	22.50
Electricity	13.00
Water and garbage	6.00
Milk	12.00
Phone	5.28
Car	5.00
Drugs (medication)	25.00
Miscellaneous	7.50
Total	146.87

[1] Fixed.

This does not include house and car insurance due January 1 (total $93).

You can see that its practically impossible to live on $160.40 per month with no savings to fall back on.

There is not much left for food especially when one is on a special diet.

This letter is much longer than I had anticipated, however, I don't know how I could explain our problem in fewer words and still be able to explain the cause of our present circumstances.

I trust the foregoing is a sample of the information you are seeking about the problem faced by our senior citizens.

The above case may be shrugged off as not being typical because the incidence of disability and the expenditures for medical care far exceed the average. On the other hand, it reflects above average ability to prepare financially for retirement. Here was a person who had "earned substantial salaries" and who started his retirement with "a nice savings account" despite years of medical expenses on behalf of his wife's mother (and, as has been pointed out, it is becoming more and more likely that people who are entering their own retirement years will have parents still living).

Still another case is noteworthy because of the painstaking way in which expenditures had been itemized in detail and balanced against income. "First of all our income is $166 per month for me and my wife." Then followed a detailed listing of "our monthly payments" and the "yearly expenditures for two." Then came the reckoning. Balanced against the income of $166 per month were monthly expenditures of $155. "For our food is left $11.54 per month. Can anyone live on this amount of money per month in this time. Yet this does not include our property tax."

Obviously, two people simply cannot exist if their only food is that which can be purchased for $11.54 a month. There must be other sources and a clue to one such source was provided during the hearings when the secretary of the director of a Golden Age Club took the microphone to say:

> I am obviously not a Golden Ager, but I wanted to speak for the people that are going to have too much pride to speak for themselves. * * * I have seen some very wonderful things and I have seen some very pitiful things. You have people in the Golden Age Clubs that the last week or the end of the month before the next check comes, there is a little bit of refreshments that are served, they come in and all that food disappears in little sacks, they take it home to have enough food to last until the next check comes in. These people have enough pride not to ask for aid or to go to the welfare agency and these people are the ones that you have to do something about.

These then are the stark realities. Countless numbers of senior citizens do not have enough income for their daily food requirements, to say nothing of the amount needed for a "modest but adequate" level that allows for normal participation in the life of the community.

In response to the question of whether "your income provides adequately for food," 93 persons 65 and older in one community answered "no" as against 110 "yes." When the same question was asked in relation to clothing, the "noes" somewhat outnumbered the "yeses"; in relation to personal care—another essential of normal participation in community life—more than twice as many persons said "no" as said "yes."

The committee is firmly convinced that the seriousness of the situation justifies immediate action to improve the income position of our aged population. We are not impressed by the line of argument that claims this is a temporary problem that will improve with the passage of time. For the more than 17 million persons now over 65, there is nothing temporary about the problem. It will be with them as long as they live, and it will get worse rather than better as health declines and financial resources are exhausted. Regardless of how optimistic the projections for the future—higher social security benefits, increased private pension coverage, and more individually provided savings—our field hearings have brought the committee face to face with the urgency of the problem right now—an urgency that cannot be shoved aside with promises of better things to come for future senior citizens.

An increase in social security benefits.—Our population aged 65 and older now numbers about 17½ million. Perhaps 1½ million of them are full-time workers—or their wives—who have not yet entered the retired ranks. Of the remaining 16 million, 12½ million are currently receiving social security benefits.

An increase in the general level of these benefits would, therefore, immediately reach almost 80 percent of the retired aged population, the great majority of whom have incomes too low to permit them to live in independence and dignity or to engage in constructive activity.

The committee is well aware of the fact that our aged population is not a homogenous group and that an across-the-board increase in social security benefits would consequently raise the income of some retired persons who already have completely adequate incomes. We do not believe, however, that this number is large enough to be significant. Nor do we believe that the alternative—providing additional income on the basis of a needs test—is acceptable. On this point, the committee is impressed by the argument of one senior citizen who reasoned as follows:

> I know people in this town, very lovely women, who are trying to live on $80 a month, and you and I know they can't possibly do it and maintain their self-respect. When I brought that up in a subcommittee of the chamber of commerce one day 2 or 3 years ago, where a man was speaking who knew about these matters, I was told that what we should do, if our social security was not sufficient, was to make application for welfare.
>
> Is that the way it should be? If we need to give people money out of welfare to augment their social security, why don't we give the social security through State welfare?

In September 1962, the monthly benefits paid under old-age, survivors, and disability insurance to retired workers aged 62 and over averaged $76.16; women receiving benefits as wives of retired workers were receiving an average of $39.60. The average for aged widows had gone up to $65.65 as a result of the 1961 amendment to increase their proportion from 65 percent to 82½ percent of their deceased husbands' benefits.

Prior to the 1961 amendment that made reduced benefits for men available at age 62, the average benefit awarded to newly retired workers during the month exceeded the average paid to all workers on the rolls—by as much as $10 in October 1959 and by $5 a year later. In October 1961, however, the average new award had dropped to $73.20, nearly $2.50 less than the average for all aged workers in current payment status. This drop reflects the significant number of men who are unable to go on working until age 65 and hasten to claim their reduced benefits. More recently, the new awards have again exceeded the average of all those on the rolls but by only about $2.

Faced with these facts, it is time to reexamine arguments which have been used in the past to counter proposals for a general increase in the benefit level. Such arguments cited the higher benefits which were then being awarded to retirees coming on the rolls and pointed out that, in the years ahead, more and more of the beneficiaries would receive amounts close to the ultimate maximums specified in the law ($127 for a retired worker alone and $190.50 for an aged couple).[9] These arguments also relied heavily on a significant increase in the proportion of retired workers who would receive private pensions (for a discussion of this point, see p. 79) and on the larger private savings which retirees of the future would have accumulated.

The committee is not attempting to predict the situation some 10 years hence. It believes that, in the year 1963, it is essential to deal with the income situation of today's aged population and to deal with this situation on its own merits. And we believe that this situation justifies an across-the-board increase in benefits, proportionately somewhat greater than the rise which has occurred in the Consumer Price Index during the 4 years following the last general increase (amendments of 1958, effective in January 1959, during which period the CPI has increased by nearly 6 percentage points).

The obligation to maintain the purchasing power of social security benefits has become an established principle of our social system—even though not generally recognized by the aged themselves who quite frequently refer to the "fixed incomes" on which they live. If benefits are increased only enough to take account of the price rise, however, our aged population is forced to undergo a continually lower level of living relative to that of other age groups in the population whose earnings give them a share in our rising prosperity. The 1961 legislation to raise the minimum wage gives added weight to the claim that wage-relative benefits should reflect current levels of earnings and not just past earnings adjusted for price increases since retirement.

[9] It should be noted that such contentions were inconsistent with projections by the Division of the Actuary, Social Security Administration, which indicated that the average benefit of all aged beneficiaries on the rolls, including wives, and widows, was expected to be only slightly over $73 in the year 1970.

The committee, therefore, adds its voice to the recommendations that came out of the White House Conference on Aging from the sections vitally concerned with this subject:

From the income maintenance section:

> The level of benefits should be adjusted from time to time in the future as it has been in the past in order, at the very least, to maintain the purchasing power of benefits. Beyond this, we believe that the aged should participate in increasing levels of living in the community and that when these increases take place benefits should be liberalized so that the retired aged, too, can participate in improved productivity.

And from the section on impact of inflation on retired persons:

> Old-age, survivors and disability insurance benefits should be adjusted to changes in prices, wages and productivity.

The retirement test.—The retirement test of the social security program, even as modified in 1960 and 1961,[10] continues to be the target for criticism whenever proposals to improve the income position of the aged are under discussion.

The pleas of individuals who wish more leeway in order to supplement their retirement benefits with earnings have more recentlv been joined by the voice of organized medicine, suggesting that the retirement test be eliminated as a solution to the problems of adequate income and protection against health costs.

As stated by one representative of the medical profession who testified at the recent field hearings:

> Many of our aged citizens bitterly oppose compelling them to retire at age 65. Many of our citizens at the age of 65 are able bodied and are willing to work to augment their retirement income. If the $100 per month ceiling could be removed, thereby permitting the 65-year-old citizen to earn what he justly deserves, his retirement income would be sufficiently augmented to permit him to enjoy better food and housing which would minimize the number of illnesses, allowing him to live in a dignified manner and enjoy life more fully. Under these circumstances if medical needs did arise he also would be in a much better position to meet those obligations.

And again, as expressed by the president of a State medical association:

> One solution to the problem of providing additional funds for health care would be to remove the present $1,200 limitation on every social security recipient's earnings, so that he could, if he wishes, earn additional income himself. * * *

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[10] Prior to the 1960 amendment, the test which applied to beneficiaries under age 72 resulted in a loss of 1 month's benefit for each $80 of earnings (or fraction thereof) over $1,200 in a year. A beneficiary could thus lose more in benefits than he gained in earnings above the exempt amount of $1,200. The 1960 amendments provided a new test which reduced the deterrent to work by withholding $1 in benefits for each $2 of earnings from $1,200 to $1,500 and for each $1 of earnings above $1,500. The 1961 amendment extended the "band" to which the $1 for $2 provision applies, making it from $1,200 to $1,700.

That elimination of the retirement test could not have any such sweeping effect on the well-being of the aged population becomes clear when one considers such facts as these:

Of the people aged 65 and over who are either drawing old-age and survivors insurance benefits or who could draw them if the breadwinner of the family were not working, the great majority are not directly affected by the retirement test because they are past 72 and therefore exempt from the test or because they do not have any earnings at all; in most cases, because they are not able to work or cannot find work. Another sizable group has not filed for benefits and is presumably not retired. Elimination of the test would mean that these workers would receive full benefits as well as full earnings. The rest—perhaps a million different persons a year—have some earnings and some benefits, and presumably are the ones who are directly affected by the test.[11]

For many older workers, employment opportunities are seriously reduced even before they reach the age of eligibility for retirement benefits. It is unreasonable to expect, therefore, that persons past retirement age will be able to earn substantial amounts.

Nevertheless, any factor—no matter how slight its impact—that works at cross-purposes to efforts to encourage full participation of older workers in productivity, for their own good and the good of the economy, merits careful scrutiny.

In the past, it has been argued that elimination of the retirement test could depress wage scales because beneficiaries might be willing to work for lower wages if they also received full benefits. The evidence presented to the committee during the course of its field hearings indicates that this may be what is happening now, with a retirement test. Here are some of the indications:

> I am a skilled machinist and I can go back in the shop today and do as good a day's work as I ever could. I am 70 years old, and the way the social security deal was handled, I am forced back into industry as cheap labor, a thing that I resent very deeply. I was offered a job awhile back by a contractor here in town in his office; he wanted to pay me in cash so there wouldn't be anything on his books to convict him, because he wanted me to work for about 25 cents an hour. Give us work or let us live respectably. That is all the senior citizen asks, and as far as these concerns having a program to employ the senior citizen, it's just all hooey. They won't hire you, any age passed 60 years old, there is no place for you anymore.

And another:

> I went to work the day after for another company, the day after I retired. I am still working, I want to work, but I resent the fact that I am only * * * that my employer is only permitted to pay me a hundred dollars a month. He knows that I am worth more than that and he would be delighted to pay me more, but he cannot do that. I think that is a very unjust thing.

[11] For December 1961, for example, 322,000 individuals had their benefit payments partially or totally suspended as a result of excess earnings.

And still another:

> I wish to enter my protest against the penalties imposed on persons who have reached the age of 65 years. I cannot see that anyone (but the employers) is benefited.
>
> As an example, if I should make a salary of over $100 a month I am penalized. I cannot begin to live on $100 a month. Consequently, I keep dipping into my savings, my employer (and all others) knows my situation, and I do the work of a $200 a month job for which I can receive but $100 a month. It is very discouraging to those beyond the age of 65, who are still alert and desperately need the money.
>
> I simply cannot see the justice of it. It seems the accomplishment of the penalties is to so beat down a person between the age of 65 to 72, so that by the time he reaches 72 he is thoroughly licked and broke. And it looks like that will be my situation by the time I reach that age. It costs an aged person just as much to live as a young person.
>
> The unfairness of the penalty of limited income is too far reaching to go into. If I were allowed to make $200 a month (and I am holding such a job for which I get but $100) I could hold onto my savings for my old, old days.
>
> Thank you for any influence you may exert to repeal the regulations regarding earned income.

The testimony gathered by the committee is replete with statements that show a misunderstanding of the purpose of the OASDI retirement benefit and of the intent and operation of the retirement test. Misunderstanding is apparent when the retirement test is challenged on the ground that a beneficiary can have unlimited amounts of unearned income and still receive all his benefits. This, at first glance, seems to put a penalty on earned income. To introduce such a test on unearned income, however, would result in a needs test and would thus be contrary to a basic principle of the social insurance program. Also, a test which applied to private savings could well serve to discourage individuals from accumulating any private resources for use in supplementing their old-age insurance benefits after retirement. Obviously the Social Security Act does not compel workers to retire at age 65—in fact only a minority of workers have claimed their benefits in the year they became eligible; it does not say that an employer "is only permitted to pay $100 a month." But equally obvious, for some workers, this effect is just as telling as though it were written into law.

The committee is swayed by the force of the argument that favors having some test of retirement in order that full benefits should not be paid to workers who—although past the eligibility age for retirement—are still continuing in their jobs and earning substantial amounts. No useful social purpose is served by paying old-age benefits which, when added to earnings, result in a higher income level than that enjoyed by the individual when he was younger, had a family to support, and was not yet eligible for such tax advantages as double exemptions on account of age. Substantial costs are involved in eliminating the retirement test, estimated to run to almost 1 percent of taxable earnings. Additional payroll taxes of this magnitude could be used instead to raise the benefit level and improve the protection of

the program in other respects, thus contributing to the well-being of the vast majority of all aged persons instead of the minority who are already in a favored position.

The committee believes that the 1960 and 1961 amendments took the right direction by introducing the principle that a beneficiary who earns over $1,200 in a year will not lose more in benefits than he gains in earnings. Whether we have gone far enough in this direction, however, is still open to question. Further liberalization along these lines may be justified, in either the exempt amount of $1,200 or in the band (now $1,200 to $1,700) where there is a $1 reduction in benefits for every $2 in earnings, or in both.

Our hearings indicated that the overriding factor in the minds of the general public is the $1,200 exempt amount. This was repeatedly referred to as "all we are allowed to earn." An increase in the annual exempt amount would therefore have considerably more popular appeal than a broadening of the band. It would also be more costly.

Perhaps sufficient time has not elapsed to permit workers to gain an understanding of the incentive factor provided by the $2 for $1 band (first effective, in general, for the calendar year 1961). More experience may be needed before it is possible to gage the effectiveness of the new test as an incentive to part-time employment, or to estimate the cost effect of further modifications.

In summary then, the retirement test continues to pose a serious problem. The problem seems unlikely to be solved until we have more clearly defined and realized our goal for the aged in respect to both employment and income maintenance.

Most of our aged do not have adequate retirement incomes. Many beneficiaries, because they cannot live on their benefits, feel they must supplement them with earnings but are limited in this effort by the retirement test.

Would the situation be different if benefits were raised to a level regarded as adequate? Our society recognizes that compulsory retirement is unacceptable but we have not yet recognized that it may be equally undesirable if older people are compelled to keep on working because they cannot afford to retire. The goal would seem to be an environment in which older people can choose freely between continuing to work in gainful employment and retiring on an income that is adequate.

Increased benefits for deferred retirement.—Proposals have sometimes been made for offering a reward in the form of an increase in the social security benefit to older workers who postpone retirement after becoming eligible. A credit for postponed retirement, it is claimed, would provide an incentive for older workers to continue in productive employment as long as possible. It would also recognize the fact that they make more contributions to the system, and to productivity in general, and receive benefits for a shorter period.

The committee believes we should carefully weigh the following arguments that have been advanced against a credit for postponed retirement: (1) The worker does not need any incentive to continue to work as long as possible; (2) the credit, to be effective, would have to be substantial and this would increase the costs of the system significantly; and (3) persons who have been able to go on working beyond age 65 are already in a relatively favorable position because they have

been able to accumulate more personal savings to augment their retirement benefits.

Valid as these arguments may be, a small increment would seem to be justified on the grounds of equity. An increase of a percentage or two for each year of postponed retirement would cost something like one-eighth or one-fourth percent of taxable payrolls. Granted that this small increase in the benefit would not serve as a significant incentive to continued employment—that it would not be the determining factor in whether a worker postponed retirement—it would nevertheless provide some recognition of the extra contribution he had made to the system.

Like the proposition for reduced benefits for early retirement, an increased benefit for postponed retirement would result in a more flexible benefit structure. No less important, public understanding and endorsement of the system are furthered by provisions of this nature which emphasize equity rather than social adequacy.

Benefits of widows and working wives.—During the course of our field hearings, we heard not infrequently from widows who had been faced with the choice of continuing to live out their lives in loneliness or of remarrying and sacrificing their social security benefit—all of the benefit if they marry a nonbeneficiary, part of it if they marry a beneficiary and give up the widow's benefit of 82½ percent for a wife's benefit of 50 percent.

We heard, too, of the growing resentment of women workers who, after years of contributing to social security from their own earnings, receive no more in benefits, or very little more, than does the nonworking wife of a beneficiary.

The committee wishes to flag these two areas for immediate consideration. What would appear to be inequities could probably be corrected with very little costs of social security funds and with great gains in public understanding and well-being of the aged.

Old-age assistance.—The fact that the old-age, survivors, and disability insurance program represents our primary vehicle for improving the income position of the aged should not cause us to lose sight of the significant role still played by public assistance in providing income for the aged, especially in many of our less industrialized States.

During the last 4 years, the number of recipients of old-age assistance has continued to drop slightly, from 2,450,000 to about 2,200,000. In relation to the rising number of people over 65, this has meant a decrease from 16 percent to about 12½ percent in the proportion receiving public assistance.

But during the latest 4-year period for which data are available [12] the number needing assistance to supplement social security benefits has increased from 596,500 to 754,700.

Currently every other newly opened case on the old-age assistance rolls is that of an individual who is receiving social security benefits but who has needs, frequently for medical care, beyond those that can be met out of his benefits and other income. This group can be expected to increase even if total old-age assistance rolls continue to decline.

[12] February 1958–February 1962.

According to Wilbur J. Cohen, Assistant Secretary of Health, Education, and Welfare, who testified before the Subcommittee on Retirement Income on July 12, 1961—

> Future trends in the number receiving old-age assistance will depend in part on the extent to which the States put into effect the program of medical assistance for the aged (the Kerr-Mills legislation) authorized by the 1960 amendment to the Social Security Act and the extent to which health costs of the aged are met by insurance programs.
>
> As shown by the excellent staff report to your Special Committee on Aging, most of the aged who have received MAA to date have been transferred from old-age assistance rolls—some 17,000 out of the 27,000 individuals in 5 States operating a program during the 6 months ending March 31, 1961. If a similar situation exists in the other States that implement MAA, there may be little net increase in the number of aged persons who received assistance in the near future. If, on the other hand, the States find that they can finance new or expanded programs primarily for people not now receiving old-age assistance, the number of aged persons receiving assistance may increase.

An analysis by the Bureau of Public Assistance (now the Bureau of Family Services) yields the following profile of the characteristics of the 2⅓ million aged persons who received old-age assistance in September 1960:

> The median age was 76.4 years—4.3 years more than the median for the total population aged 65 or over.
>
> Women comprised 66.3 percent of the persons receiving OAA.
>
> By marital status, 54.2 percent of all recipients were widowed (66.3 percent of the women and 30.4 percent of the men); 27.5 percent were married; 9.4 percent divorced or separated; and 8.9 percent had never married.
>
> Because of physical or mental conditions, 20.3 percent were confined to their homes and 7.5 percent were bedfast or chairfast; half of the latter group were living in institutions. Of recipients not confined to their homes, 1 in 9 needed help to get around outside the home.
>
> Almost two-thirds, 64 percent, of the recipients lived in quarters maintained as their own households, 15.5 percent lived in homes of sons or daughters, and 8.8 percent were in institutions; the remainder had other living arrangements.
>
> Of all recipients not in institutions, 94 percent had electric lights; 87.1 percent, refrigeration; 74.2 percent, running water in building; 66.8 percent, flush toilet; and 53.7 percent, ready access to a telephone.
>
> A majority, 57.4 percent, lived in nonmetropolitan counties.
>
> The median time since most recent opening for OAA was 6.1 years. For those who received OASDI benefits the median was 3.9 years; for those not receiving such benefits it was 7.2 years.

Of all recipients having nondependent children, 23.5 percent received contributions from the children.

OASDI benefits, averaging $44.03 per month, were received by 29.7 percent of all recipients; 38.3 percent of the men and 25.3 percent of the women received such benefits.

Only 2.7 percent received benefits or pensions other than OASDI.

Income other than assistance averaged $46.26 a month for recipients who received OASDI benefits and $5.80 a month for those not receiving such benefits.

Monthly requirements recognized by the States averaged $84.61 per recipient. Income to meet these requirements averaged $80.72, including $17.82 in income other than assistance, and OAA payment of $62.74, and a supplementary general assistance payment of $0.16. This left an unmet financial need of $3.89 a month per recipient.

The committee's field hearings cut through this national summary to obtain a picture of the old-age assistance programs of 13 States, from the vantage point of assistance recipients themselves who spoke out at town meetings, as well as from expert witnesses. Information was provided by State and local administrators of the program and by others—State officials with responsibility for the licensing of nursing homes, operators of nursing homes, mental health commissioners, housing officials—whose programs are vitally affected by the operations of the old-age assistance program.

The States in which the committee held hearings spanned those where the proportion of aged persons who received assistance was fewer than 1 out of 20 (New Jersey and Hawaii) and was as high as 1 out of every 4 or 5 (Missouri). In the more rural counties of Missouri, as many as 7 out of every 10 aged people are recipients of old-age assistance. Nationwide, the proportion was about 1 in 7.

During the course of those hearings, the committee was provided with a picture of the program's impact on aged citizens in the local community, in a depth and detail not previously available and personalized with case histories.

The following were three "actual" cases showing typical circumstances surrounding the financial deterioration of retired persons and leading to their dependence on welfare programs:

Mrs. A, who had been receiving general relief due to her extended illness, applied for old-age assistance when she reached the age of 65. She had been going to a hospital at least once a month. She had been receiving social security benefits since March of 1959, but still had not been able to meet her expenses and medical care costs. Three admissions to the hospital met the eligibility requirements for payment through the State vendor plan in the amount of $240. However, currently Mrs. A owes a local hospital $8,691. This is the amount due after deeding her property worth $2,000 to the hospital. Her current monthly medical expense is $67.58. She owes her physician approximately $1,500. Her only in-

come is the social security payments in the amount of $73.95 and her old-age assistance in the amount of $65.[13]

Mrs. C applied for old-age assistance in May of 1960. She said she had used most of her money, and she had kept boarders, and then she and Mr. C had lived on social security payments. But because of medical expense, they had used most of their savings. Mr. C died in 1959. Mrs. C stated that her medical expense was high, and it was difficult for her to manage without spending her savings. She had only $143 left. She had no life insurance. She owned one-half interest in a piece of property. She had a small amount of furniture.

Her total expense, including $14 a month for medical care, was $86.06; after deducting the OAB in the amount of $33, Mrs. C had a deficit of $53 and was entitled to this amount of old-age assistance.

Mrs. D stated she was no longer able to work. Her husband died in 1958. They had used all their savings for hospital and doctor bills, and now she could not meet her needs on $77.60 of social security.

Her total expenses were $108.29 a month. She needed a grant of $31 old-age assistance to meet the deficit.

These illustrative cases were drawn from the files of a county which had a decreasing number of cases on old-age assistance—a drop of close to one-fourth in the last 10 years. Careful attention was being given to the reasons for opening new cases and the characteristics of the new applicants. These findings with respect to 170 case records are worthy of note:

Using the principal reason for application, as given by the client when he came in to make his request, illness and medical expense led the list with 37 percent. Another 19 percent reported "depletion of savings."

The average age of the new applicants was 73.2 years. Nearly two-thirds were women.

In reviewing living arrangements, it was found that 28 percent lived in their own homes; 21.8 percent lived in nursing homes and boarding homes; 38 percent in rented shelter; and 11.2 percent had shelter supplied by relatives. 31.7 percent owned real property; 50.7 percent, no real property, but some other types of property; and 17.6 percent, no property whatsoever.

Of the applicants, 53.5 percent received some type of social security benefits.

In nearly two-fifths of these cases there was a budget deficit—that is, the maximum old-age assistance grant plus other income still did not meet the total needs of the individual. The average deficit unmet was $35.30.

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[13] $65 is the State's maximum for ambulatory persons; the maximum for the completely bedfast is $100.

Of these new cases, 62 percent had some medical expense, ranging from a small amount for medicine to large expenditures for doctor and hospital services. The average cost per person for current medical care was $22.71 per month. This included physicians' services, medication, dentures, eyeglasses, and some hospital services.

About 30 percent of the cases with medical expenses received some payment from the State vendor payment (which is this State's way of paying part of the hospital bill). However, this did not meet the total bill, so there was left a balance due averaging more than $120 per case.

In this State, some county medical care is available but under a very limited budget (with a total population of about 30,000, the county's budget for hospital care is $5,500 and the total for medicine is $3,000 per year). Only 1 of the 170 cases studied was eligible to receive county medical care under the eligibility requirements set by the county health office. Those not eligible either "do not receive medical care, or they do not pay their hospital bill or their doctor."

A 1960 study by the Bureau of Family Services provides a nationwide measure of the extent of unmet financial need which documents the situation presented to the committee in its hearings. This study reports:

Considerably more than half the States fail to make OAA payments adequate to meet their own income tests of financial need. In these States some or all payments are subject to limitation, irrespective of the amount of assistance needed as determined under the State's test. For the country as a whole, unmet financial need averaged $3.89 a month per person receiving OAA. This amount represented the difference between the average cost of all requirements recognized by the States and the average of all income available to recipients to meet these requirements, i.e., income other than assistance, OAA payment, and supplementary general assistance. The average unmet need represented 4.6 percent of the average amount budgeted for requirements.

Some States having relatively low amounts as the test for income needed may show little or no unmet financial need for their OAA recipients. In such States the average level of living actually provided persons receiving OAA may be lower than in States that recognize a higher level as an income test of "need" but do not fully meet that responsibility with the assistance paid. State variations in respect to budgeted requirements and average payments will be presented in a subsequent release.

An unmet financial need of $3.89 a month per person receiving old-age assistance takes on added significance when it is related to the total budgeted need of the average assistance recipient. It then leaves a gap of nearly 5 cents on the dollar, a most significant amount to persons who are trying to get along on minimal incomes of $2 or $3 a day.

In 1962, the Congress recognized the inadequacy of the old-age assistance payments by increasing the Federal share by approximately $4 a month and by making permanent the temporary $1 increase voted in 1961.

In enacting the legislation, the Congress made clear its intent that the additional Federal funds be used by the States to raise payments—that is, that the increase be passed on to the recipient and not be used merely to lower State expenditures. The committee wishes to call special attention to the intent expressed by the Congress; witnesses at our town meetings frequently complained bitterly that they failed to receive the increases in income that had been expected when Federal legislation was enacted (see below "Assistance Recipients Who Also Receive Social Security Benefits").

The Public Welfare Amendments of 1962 were significant too in their provisions to encourage old-age assistance recipients to contribute to their own support. In determining needs, States may disregard the first $10 and half of the next $40 of monthly earned income, thus permitting the elderly recipients to have up to $30 a month of earnings without deduction from the assistance check. This, too, was a liberalization urged during the committee's field hearings.

The new amendments emphasize the prevention of dependency—the constructive approach to public assistance—by providing increased Federal matching in State expenditures for social services and training activities. Obviously, the opportunities for prevention of dependency among old-age assistance recipients are not of the same magnitude as among younger assistance recipients. We do not expect large numbers of OAA recipients to be rehabilitated for employment, thus showing concrete savings in dollars and cents. But there are tremendously important gains in human values to be achieved through rehabilitation of an older person for independent living—and there are even opportunities, largely untapped, for concrete savings in assistance costs through expenditures on improved rehabilitation services.

Assistance recipients in nursing homes.—Of the 2⅓ million recipients of old-age assistance in October 1960, nearly 150,000—6.1 percent—were in nursing or convalescent homes. Witness after witness testified to the special problem of payment rates for assistance recipients in nursing homes.

Assistance to individuals on conditional release from mental institutions.—Experts testifying before the committee stated that there are literally thousands of old people in mental hospitals who no longer need to be there—in fact, whose condition can be expected to worsen if they remain there—who could live satisfactory, meaningful lives if they were moved to surroundings which provide the emotional values they need so badly. Our States are trying to restore these people to normal community life. Many have no families of their own—no homes to which they can return. For them, nursing homes or foster homes can provide a far more satisfactory life and care more suitable to their condition than can a mental institution.

During the field hearings held by the Special Committee on Aging during the fall of 1961, we heard from a number of States about their programs to return former mental patients to normal community life. But we were also told that our Federal old-age assistance law imposed

a serious barrier to the efforts of the States. Witness after witness, especially those working in the field of mental health, called attention to the "discrimination against the mentally ill" which results when the Federal old-age assistance law—or its interpretation—rules out the former mental patients who are on conditional release.

We learned that virtually all States have had to resort to devices to circumvent the problem imposed by the Federal law. To the extent that the circumvention involved premature nonconditional discharge or excluded the mental institution from participating in the program of care, such devices could do serious harm.

Our committee, therefore, flagged this as an area for urgent attention in its 1962 report which accompanied Senate Resolution 238 to extend the life of the committee. As stated therein, our aim was to develop "recommendations for changes in the Federal law and in the administrative interpretations thereof which are in step with modern thinking and which recognize and encourage the various efforts of the States in tackling this problem."

We are happy to report that corrective steps have now been taken. In June of 1962, the Commissioner of Social Security informed the committee that policy material liberalizing the interpretation governing Federal financial participation was sent to the States on June 15.

Two changes in policy have been made. As described in letter No. 571 from the Bureau of Family Services, Social Security Administration, to State agencies administering approved public assistance plans, these are:

> First, the change in definition of "inmate" permits Federal financial participation in assistance payments to or in behalf of persons who are on conditional release from mental institutions without regard to the kind of control still exercised by the institution. Second, Federal sharing may be available with respect to persons on convalescent leave who enter medical institutions, including nursing homes, other than specialized institutions for care of the mentally ill. Persons in mental institutions are excluded, as are persons receiving care in medical institutions as a result of a diagnosis of psychosis.

One further quote from State Letter No. 571:

> This new interpretation does not contemplate a mass movement of persons from mental institutions into the community. Rather, by it very nature, placement in new living situations of persons on convalescent leave is a highly individualized procedure.

This caution is appropriate. Nevertheless, a giant stride has been taken through the new opportunity afforded State assistance agencies to work jointly with mental institutions in the rehabilitation of persons ready for convalescent leave.

The Special Committee on Aging will continue its interest in this important program to improve the welfare of persons who would otherwise live out their days behind institutional walls. We hope the States will keep us informed of program developments. We will welcome their comments on the effectiveness of the new policies in meeting their needs.

Assistance recipients who also receive social security benefits.—Approximately three-quarters of a million aged persons now receive old-age assistance to supplement their social security benefits. These people represent one-third of the total old-age assistance case load nationally, but a considerably higher proportion—about one-half—of the cases now coming on to the rolls. In areas where the committee held hearings, persons receiving both assistance payments and social security benefits accounted for as much as 70 percent of the old-age assistance caseload.

It was from these individuals that our committee heard during its town meetings of senior citizens. Their common problem was the loss of part of their old-age assistance grant following the long-awaited increase in the minimum social security benefit. Here is the problem as related by four of them:

> We find that our people, who are the senior citizens, of course, and who are all in one form or another drawing social security, are very much perturbed because of the fact that they just can't get along on what they are drawing. They were very encouraged when, on this new bill, this increase came through. Then when the welfare cut the same amount from their monthly benefits by $7, which they were increased, there was a tremendous effect psychologically on the people.

> Mr. Chairman, every commodity you can name has risen in price in the past few years. Every piece of property has also followed the same pattern. Every rental establishment has had its rent upped and upped. Taxes have been almost doubled, and I could go on and on with innumerable subjects. However, when we come to our aged, we find the vast majority are still drawing the same old social security check they got years ago. Yes, there was a slight raise for some receiving small benefits, but, in most of those cases, we find the welfare department in the various counties have taken this from these people by simply withholding an equal amount from their next welfare check.

> I am supposed to be a retired citizen. What I would like to say—I haven't heard it mentioned here today—the money that is turned over to the State that is supposed to be for social security, or from that fund, it is turned over to the people to help people here who draw some social security, and they get some State assistance, and through the source of that, through the State assistance part of it, usually whatever is turned over from the raise from the Federal Government into the social security that they're supposed to get, they don't get it. It's taken off on the other end by the State, and I presume its put into the general fund or used for some other purpose.

> Now I would think there would be some preparation through your Congress to find out whether the people, who were supposed to get it, really got it, or if they didn't send it to the State for the simple reason to balance the budget, or raise the salary of somebody that's already getting considerable money. That looks like a good simple way of doing it.

> I have in mind about a particular woman, who was receiving $33 social security. Then that was raised up by $50 from the department of public assistance, giving her $83 a month to live on. Now the Federal Government increased her social security $7. For a person who is trying to live on $83, $7 is quite a little and it meant quite a bit. So what happened? Immediately they got the increase in social security, the public assistance department took away $7 from her, and all of those people who thought they were going to get an increase are still getting along on their $83.

We have called attention above to the expression of intent by Congress, that the 1962 increase in the Federal share of old-age assistance payments should be passed on to the recipients. If social security benefits were to be increased, all beneficiaries—including those who also receive assistance—would, of course, expect to see a corresponding increase in their total income. Some States that are already making assistance payments up to the amount of budgeted requirements, however, would either have to reduce the assistance payment by the increase in the social security benefit or raise payments correspondingly for the nonbeneficiaries. We shall request the newly organized Welfare Administration of the Department of Health, Education, and Welfare to prepare an analysis of the State-by-State effect of a social security benefit increase on the assistance payments, with recommendations which would insure that such increases reach the beneficiaries.

Surplus Foods

Hundreds of thousands—perhaps even millions—of the Nation's older people do not have enough to eat. We learned at our hearings of the way in which the cakes and cookies served at golden age clubs and activity centers are pounced upon, ravenously eaten on the spot, or hoarded for a future meal. We heard that the sense of pride which is one of the aged's most cherished possessions sometimes causes him to go without food in the privacy of his own home so that he can be presentably dressed in public.

We learned too of the relationship of malnutrition to mental illness from an expert witness who said:

> We had the opportunity 2 years ago to visit in England where we found the people who were very concerned about the problem of the elderly firmly convinced that many of these mild states of confusion were due to malnutrition and that if they could send in one good hot meal a day they kept many patients out of the hospital.

The additional factor was that they operated a great many day care centers for the elderly and they were convinced also that the fact that the patient came and stayed there all day, had one good well-balanced meal at the day care center, helped to keep him out of the confusional state that comes with malnutrition.

In most parts of the country, only a beginning has been made in the effort to use surplus foods in supplementing the food supply of our aged population.

One State that had just embarked on statewide distribution of surplus Federal commodities reported as follows:

For the first time in State of Washington history, the 1961 session of the legislature passed an act providing for statewide distribution of surplus Federal commodities. This act carried with it an appropriation of $2,492,000, with which to perform the actual act of distribution from the three warehouses located in eastern, central, and western Washington, to our 32 retail outlets located in 30 of the 39 counties of the State, and from these outlets to our customers. We also have satellite distribution from some of our stores into four more of the counties, giving us an almost saturation coverage of the entire State, as far as availability of food is concerned. We operate strictly on a customer-clerk approach and give special consideration to our senior citizens.

Since the beginning of statewide distribution of surplus food commodities in June of this year, we have served approximately 106,963 monthly food issues to senior citizens assistance grant recipients, and 9,208 to persons 62 years of age and over, who are not recipients of assistance grants. The monthly average of the above is 22,940 old-age assistance, and 2,050 people 62 years or older. This has resulted in the issuance of 2,323,440 pounds of commodities, having an actual retail value of $929,376. Investigation has shown that the intrinsic value of the commodities distributed is not a true figure because of value of the food that is eliminated by the receipt of our commodities. This is along the line of pastry mixes, pancake flours, and items of similar type that the commodity recipient will not buy because of the fact that they are granted all-purpose flour from our stores. Our findings are that this increases the value of the products from $8 per person per month to $17.50 per person per month.

The commodities distributed are made as easily available to our senior citizens as possible, even to the extent of a very well organized statewide good neighbor program being conducted by many groups in various areas of the State. The groups assisting in this type of activity are furnishing transportation for people finding it difficult to get to the stores and, in some cases, actually include the delivery of the commodities to the recipients' homes. We are pursuing this phase of our program to the fullest extent of our ability and feel that at the present time such service is available to at least 95 percent of the people in this category who are eligible for surplus foods.

> Another aid being offered to recipients is the statewide program of demonstration as to the use of some of the commodities, with which the people might not be familiar, particular emphasis being placed on powdered eggs, powdered milk, and corn meal. This activity is being carried on by the home economics division of the various organizations, namely the county health offices, county agents under the supervision of Washington State extension service, power companies, and so forth. The reaction to the program by our elderly citizens has been almost completely one of gratitude. We think that this grant is filling a longtime need for nutritional supplements to our low income diets.

In other States, the problem of distribution—and the lack of State funds for this purpose—has seriously hampered efforts to get surplus foods into the hands of the needy aged. There have been instances when State and local governments withdrew from the program because the local costs of certification and distribution were considered to be excessive in relation to the value received from a limited variety of surplus foods.

This Nation has accumulated and is maintaining in warehouses tremendous quantities of surplus commodities—including edible foods—at a cost to the taxpayer which, including interest and transportation as well as warehouse charges, has been estimated to amount to nearly a billion dollars a year.

Are we not pennywise but pound foolish if we fail to remove the barrier that now stands between the warehouse and the potential consumer? Insofar as this barrier is the inability of our States and communities to finance the distribution of foods, every consideration should be given to Federal sharing in these costs.

Other possibilities for broadening the use of surplus foods demand attention. Do all of the individuals who could be eligible know of the availability of foods? Are nursing homes and other institutions that serve eligible persons making use of this program to the extent possible? One specific example called to the committe's attention is that of an activity center for the aged under the auspices of the recreation department, which serves a hot meal each day. No charge is made—the locality considers this a "public service"—but the burden of providing this service would be more manageable if surplus commodities were available. It is known that many of the older people who use this service are needy, but the sponsoring agency is most anxious not to identify them as such. Can it qualify for surplus foods? Questions like this have apparently been worked out satisfactorily in some States. There does not, however, seem to be any vigorous promotional channel for sharing this kind of information. Here, again, the Federal Government may need to take a more active role in promoting the distribution of surplus commodities by serving as a clearinghouse for information about certification methods that are successfully employed in the States, about the use of voluntary agencies in distributing foods and the like.

Another area for exploration is the use of surplus foods in programs of meals-on-wheels. Such programs, not yet widespread in this country, are designed to furnish an adequate nutritional diet to persons who are homebound and cannot provide adequate food serv-

ice for themselves, frequently after a hospitalized illness or while awaiting admission to a nursing home. Users of the service pay for it, if financially able to do so. A change in our Federal legislation would appear to be necessary in order to make surplus foods available to these programs. This, along with all other possibilities for improving the diets of older people through the use of surplus foods, merits immediate attention.

Retirement Income and Private Pension Plans[14]

A major question mark which has arisen a number of times during the field hearings of the committee concerns the role which private pension plans should, can, and will have in future efforts to provide adequate incomes for people who retire. In spite of income improvements during the 1950's the continuing need for more substantial retirement incomes is well established, both from formal studies of the income picture among the aged and from virtually every page of testimony taken in committee hearings on retirement income.

Granting the need for substantial improvement in retirement income the question remains: What is the most effective way to accomplish these improvements? A most important corollary question is: How will the alternative ways to achieve more adequate retirement incomes affect various segments of our diverse aged population? This corollary suggests that the need for greater retirement income is more acute in some segments of our aged population than in others and that the alternative means to improve the retirement income picture should be assessed by criteria which recognize these relative differences in need among our aged citizenry. The likely future role of private pension systems is a case in point.

In 1960 total benefit payments from private pension and deferred profit-sharing plans have been estimated to amount to at least $1⅓ billion. This is four times as great as similar payments made in 1950. Other measures of growth also attest to these substantial gains made by private pension plans in recent decades. It has been estimated that about 20¼ million workers are now covered by private pension plans. About 43 percent of the employed private wage and salaried labor force now have such coverage as compared with about 23 percent in 1950.[15]

Despite these substantial gains benefit payments from private pension plans today make up only a small fraction of the aggregate income for the aged. In 1960 less than 6 percent of the estimated aggregate income of persons 65 and over was accounted for by private pension benefits and individual annuities combined. The 1957 national survey of old-age and survivors insurance beneficiaries indicated that about one-fifth of the retired worker beneficiaries received benefits from employer pension plans but that these benefits made up less than 9 percent of their aggregate annual income. Since the growth of private pension plans is a recent development they will, of course, account for a greater share of retirement income in the future but not

[14] Much of the material in this section of the report was developed by Dr. Frank Atelsek, formerly on the staff of the committee and now serving as Program Officer for Economic Planning in the Area Redevelopment Administration of the Department of Commerce.

[15] Social Security Bulletin, April 1962, "Employee-Benefit Plans, 1954–60," by Alfred M. Skolnik.

for current retirees. It is clear that those who now receive private pension benefits are those of the older population with the highest incomes. Over half (51 percent) of the OASI beneficiaries receiving employer pension benefits have total money income of $2,400, or more. Put another way, less than 3 percent of the low-income beneficiaries, those whose income is less than $1,200, receive benefits from private pensions.

The field hearings of the committee produced some differences of views about what place private pension systems would have as a future source of retirement income. One view points to the truly dramatic increases in private pension plans and concludes that private pensions will form the broad range answer to present-day inadequacies in retirement income. Explicitly or implicitly it is sometimes suggested that any move to develop public retirement income programs above a subsistence level may in fact impede the progress of these private plans.

> The first level might be described as the "dependency" level. This is the level of income needed to guarantee the basic needs of postretirement living, food, shelter, etc. Expressed in another way, the "dependency" level is that amount of income which is necessary to free the individual from becoming dependent on society for the necessities of life.
>
> Relating social security to the dependency level of income does not imply that benefits under the Government program should be static. Instead they should be changed whenever alterations in living costs change the amount needed to eliminate dependency. However, it does mean that social security would not increase in the future to try to offset a higher proportion of pay if not needed for dependency reasons.
>
> A second theory is that social security should continue to expand until it reaches the level of adequacy. Under this theory the Government program is intended to be a form of income replacement and should currently do for all citizens what some of them cannot do for themselves or through their employers.
>
> Frankly we believe that the appropriate role for social security is to replace needs at the dependency level. There should be room for individual and employer action in meeting the standards of adequacy.[16]

A more reserved view, while recognizing the substantial gains in private pension planning, and willingly predicting additional increases and improvements, nevertheless maintains that private pension systems presently have serious limitations which must be first overcome before these plans can claim a place as a major solution to the retirement income problems of the future.

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[16] From the statement of Edwin S. Hewitt, partner, Hewitt Associates, consultants and actuaries on pension and employees benefits; hearings before the Subcommittee on Retirement Income, July 12–13, 1961, Washington, D.C., pp. 130–131.

> Obviously there is no easy solution to this major problem. Present efforts seem concentrated on improving the legal safeguards of existing fixed-dollar programs. Little concentration is given to their adequacy. It is recognized that some labor unions and some enlightened employers have tried to cope with the problem. However, their efforts have been highly individualistic and haphazard in approach. * * *
>
> * * * the retirement income problem seems to require compulsory uniform cooperation from Government, employer and employee * * *. It is only through the upgrading of social security requirements—supplemented by legally sound and supervised private pension programs * * * and through improved legislation directed toward meeting increased medical costs * * * and through a recognition of the varying (upward) rather than the fixed dollar concept that the basic problem of adequate retirement income can be solved. Such concerted action should not be decried as another step in the direction of the welfare state. Any improved program which requires contributions by employer, employee, and Government to meet a problem as fundamental as this is democratic. * * * [17]

While it is clear that private pension systems have grown rapidly and will contribute an increasingly larger share of the income resources of the retired population, several of their current characteristics suggest that the present trends in growth will not alone automatically guarantee that private pensions will become a significant universal source of retirement income. In the absence of widespread early vesting [18] and much greater coverage under adequate private plans, OASI benefits will continue to be the main reliance of a majority of retired persons in the future as it is today.

The actual growth of pension plan coverage has often exceeded knowledgeable estimates. In recent years over 1 million additional employees have been covered annually so that the total number of workers covered by private pensions is now well over 20 million.

Most of the pension plans recently established were products of collective bargaining and tend to be concentrated in the larger firms within a few industries.

Small firms generally have been unable to establish and maintain liberal pension plans.

At the committee hearings on retirement income held in Washington, in July 1961, Edwin S. Hewitt listed the following conditions as major factors inhibiting pension plan development among small employers:

> (1) There has been less competitive pressure for pensions on the small employer than the large, but it can be expected to increase as pensions spread.
>
> (2) Frequently the small employer's economic position discourages consideration of retirement programs.

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[17] From the statement of Sterling Surrey "Hearing on Retirement Income," Nov. 29, 1961. Springfield, Mass.

[18] For an explanating of the term "vesting," see below, p. 85.

(3) The small employer's employees are less likely to be organized than those of the large employer. Hence, he is less subject to union pressure for pensions.

(4) The alternative types of plans offered to the small employer may be limited.

(5) The small employer may be ill equipped to cope with the intricacies of different kinds of plans. The cost of dealing with these intricacies is not reduced proportionately because of size and may act as a deterrent to action.

(6) The small employer is likely to be uninformed and apprehensive about the requirements of the Treasury Department in establishing and maintaining a qualified plan.

Among positive conditions which would tend to encourage small employers to adopt plans are the following:

(1) Availability of more plans carrying lower acquisition costs.

(2) Further development of multiemployer arrangements, through associations, community groups, or fiduciary institutions, where installations and administration costs and/or investment experience and possibly mortality experience can be pooled.

(3) Simplification of Government requirements.

(4) Better education of small employers as to the considerations involved in establishing and operating a retirement program.

(5) General encouragement of the economic welfare of small business through Government action unrelated to pensions.[19]

Private pension plans also are not equally represented among the major categories of industry. Trade and service industries which may be characterized as relatively low wage industries, while making up about a third of the U.S. labor force, have established relatively few pension systems. A background paper to the White House Conference on Aging puts this problem well:

> This enormous complex of industry with its hundreds of thousands of small businesses and its millions of self-employed people, has not been very hospitable to the development of private pension plans. There are notable exceptions, including large chain and department stores. It is, however, in the trade, service, and agricultural areas, with their large numbers of aging workers who seriously need the assurance of retirement income to supplement their OASI benefits (if any), that the private pension idea faces its most difficult and critical challenge.[20]

There are substantial gaps in coverage by private pension plans which are not likely to be overcome in the near future.[21] Many millions of workers in small firms and in industries characterized by

[19] Ibid., hearings before the Subcommittee on Retirement Income, July 12, 1961, p. 133.
[20] White House Conference on Aging Background Paper on the Employment Security and Retirement of the Older Worker, pt. B, p. 21.
[21] This discussion of private pension plans would not be complete without reference to

irregular employment are unlikely to gain private pension rights as presently conceived until they are effectively organized and are in a position to bargain collectively. Agricultural workers, particularly, seem beyond the scope of present day private pension systems. Only in the rare instances where farmworkers are unionized on an industrywide basis, as with the sugar workers of Hawaii, have pension plans developed in any important degree.

Legal rights of pensioners under private plans.—This aspect of private pension systems was touched on only slightly in the hearings of the committee. It seems worthwhile, however, to review some of these problems in order to underscore them as topics deserving further study in the future.

As stated by one witness, the basic weakness of existing plans lies in the fact that, by and large, the legal rights of the pensioner are virtually nonexistent.

> The pensioners, both present (i.e., now retired) and future (those below the retirement age), must rely upon the moral integrity of the creators and administrators of these programs rather than on legal compulsion. Federal legislation falls far short in protecting the interests of participants and of their beneficiaries.[22]

Among the points Professor Surrey makes to support this contention are:

> (1) Where pension trusts are created, the trustees are not subject to any regulation except those general State and Federal laws applicable to any personal trust.
>
> (2) The trustee is not sufficiently liable for imprudent investments except when due to negligence, willful misconduct, or lack of good faith.
>
> (3) The existing statutory and judicial controls are weakened by the fact that legal action for remedy of any abuses must be taken by the participants who often lack the necessary knowledge of the plan and its finances required to protect their rights. There has been some improvement in the Welfare and Pension Disclosure Act. Recent amendments to the act provide certain authority to the Department of Labor to enforce compliance with the act.
>
> (4) In the absence of specific provisions required by law to be included in every pension plan, the legal rights of the employee are primarily determined by the terms of the plans themselves.

Some of the legal safeguards which have been suggested to protect the pension expectations of the participants include:

> (*a*) A firm legal commitment to the employer to assure liability for pension rights. Some plans now have explicit disclaimers of such liability making the position of the employee participant most uncertain. If the employer fulfills his obligations as stated

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Public Law 87-792, enacted by the Congress in 1962, "to encourage the establishment of voluntary pension plans by self-employed individuals." (See p. 183 above.) We believe that any attempt on our part to evaluate the long-range effect of this measure would be premature. Hearings and reports on the measure (H.R. 10—1961) are available from the Committee on Ways and Means in the House and the Committee on Finance in the Senate.

[22] Sterling Surrey, Springfield, Mass., "Hearings on Retirement Income," Nov. 29, 1961.

in the plan, the employee has no legal means by which to collect the promised benefit, should the pension plan prove to be insufficiently funded.

(*b*) The Bankruptcy Act does not now give past-due employer contributions to pension plans the same priority as it does to wages. Claims against an employer for pension contributions should be given preferred status.

(*c*) Consideration might be given to the feasibility of establishing at least minimum standards on the funding and investment practices of pension plans.

(*d*) Permanent layoffs of worker participants in pension plans frequently follow company mergers. The pension rights of the affected employees should be protected in such circumstances by providing for full vesting of their pension right at the same time of such layoff. Such protection is already provided in some plans and might reasonably be required of all.

Pension plan terminations.—The outright termination of a pension for reasons other than merger can also have serious consequences for the pension plan participants. About 1,400 terminations of pension or deferred profit sharing plans were reported for the years 1956–59. As one witness pointed out, such terminations may occur for a variety of reasons, some to the advantage of the participating worker:

> * * * we now have a study which is about a third completed under the subheading of "Pension Plan Termination, Cause, Provision For, and Consequences." We have found that as a matter of fact there are many pension plans that have been terminated. I do not wish to state that these terminations are adverse to the interest of the employees. For example, some pension plans may have been terminated, because they were superseded by better ones. That is possible and frequent. We hope that they would be the majority.
>
> There are other pension plans that have been superseded not necessarily by some that are either better or worse, but different ones. For example, there may merely be a revision that is sufficiently drastic so that rather than to be classified as an alteration, it really is a different plan.
>
> We would like to know a lot about many of those plans. Why did they terminate? Were there any losses, substantial or otherwise? Were there gains? What can we find out about them?
>
> Our feeling is that if there is a significant number of terminations, it would be desirable to make a reasonably thorough study, and if we could find that there are certain problems, then it would be desirable to pinpoint those difficulties so that they could be removed quickly, or so that safeguards could be immediately instituted, whether on a State or Federal or other basis, to decrease the likelihood of the recurrence.[23]

Since there is virtually no information available on the effect of actual terminations upon the rights of the participating workers,

[23] From the statement of Erwin A. Gaumnitz, dean, School of Commerce, University of Wisconsin, hearings before the Subcommittee on Retirement Income, July 12–13, 1961, Washington, D.C., pp. 80–81.

studies of the sort cited by Professor Gaumnitz should prove valuable. Some indirect protection of worker rights is provided by the Internal Revenue Code which states that—

> * * * although the employer may reserve the right to change or terminate the plan, and to discontinue contributions thereunder, the abandonment of the plan for any reason other than business necessity within a few years after it has taken effect will be evidence that the plan from its inception was not a bona fide program for the exclusive benefit of the employees in general.[24]

Arbitrary terminations of pension plans, then, would revoke the tax advantages available to the employer under the code and thereby serve to protect the interest of the employees under the plan since the tax advantages gained by the employer who maintains a qualified pension plan are substantial.

Analysis of actual terminations would provide further information on the kinds of "business necessity" which require the termination of existing plans and may well suggest means by which the worker-participant in a plan may be better protected against the loss of pension rights.

Vesting of pension rights.—The suggestion that the vesting of pension rights be promoted and encouraged was a dominant thought among several witnesses appearing before the committee.

At this point, it may be well to illustrate the usual meaning of the terms "vesting" and "portability" of pensions. A vested pension plan is one which provides the participating worker with some guarantee of an equity in the pension plan, even if he loses or leaves his job before reaching retirement age. Usually a worker is eligible for vested pension rights only after having worked a specified number of years for the firm and/or after reaching a certain age. Thus worker A may be employed for 30 years with a firm having a pension plan which lacks a vesting provision. Should he lose his job before normal retirement age, he would lose all but a refund of his own contributions to the plan (if any). In the same circumstances, worker B participating in a vested pension plan would be assured at least a partial pension upon his retirement.

Stated another way, "vesting" guarantees the payment of accrued pensions at a normal retirement age, to terminated workers meeting a pension plan's vesting requirements. To give another example, both worker A and worker B have been working for company X and Y, respectively for 15 years. Both companies contribute to their pension funds $200 a year for each employee. Both men are permanently laid off soon after they have celebrated their 40th birthdays. When worker A reaches age 65 he will be paid a monthly pension of $37.50 for the rest of his life by the company X pension fund because it has a vesting provision. Worker B is not entitled to any benefit because the company Y plan does not have a vesting provision and he did not continue working for the company until he became 65 and entitled to a pension. In the case of worker A a right to money paid into the fund while he was working for the company was vested in him, the worker. Worker B, on the other hand, had no vested right at all unless he worked for the company up until retirement age.

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[24] Treas. Reg. sec. 1401-1(b)(2) (1956).

Pension "portability" on the other hand usually refers to the feature of a pension plan which allows a worker who moves from one employer to another to continuously accrue rights to pension benefits. Under the portability of pension credits provision, full pension credits are allowed for service with any employer belonging to a specified group. Social security credits, for example, are fully portable among all employers covered by the Social Security Act. So are credits under multiemployer pension plans such as those of the United Mine Workers, Teamsters, and Clothing Workers. Worker P, for example, works for employer E who belongs to multiemployer plan M. After working for E for a year or two, P gets a job with employer F—another member of plan M; a few years later he switches to another member employer; and so on until he retires. At that time, he receives credit for all the years he has worked for E, F, G, etc. But employee N, by contrast, works for employers in the same industry with their own individual pension plans; they do not belong to plan M or any other multiemployer plan. When he retires he only gets a pension from his last employer unless he is entitled to a vested benefit from a previous employer's plan. Unless a vesting provision is also included, the portability feature applies only as long as the worker confines his job changes to participating employers. As in our example, such plans are usually organized along industry lines or on an area basis. Perhaps the best example of almost complete portability is the social security old-age, survivors, and disability insurance program, under which individuals may change jobs in covered employment countless times yet have benefit rights from each job accrue in one pooled fund. Even in the multiemployer plans, however, the worker is generally permitted mobility only among the firms incorporated in the pension system and would ordinarily have to forfeit his pension rights were he to work elsewhere.

As stated by one witness:

> A vested program is far superior to one in which the employee, if he loses a job, perhaps through no fault of his own, like a depression, sees his accumulated pension to date vanish. I believe the trend is going to be toward vesting with very moderate restrictions on how much vesting, and the period of time. I think we are going ultimately to get to complete vesting after a period of a few months of employment.[25]

Although no definitive information is available on the extent of vesting in present-day pension plans, pension experts have estimated that more than one-half of all covered employees were members of plans having some vesting provisions. There is, however, a wide variation in the conditions under which a worker is allowed to leave his employment before reaching retirement age and still retain the right to receive deferred benefits based on his accrued service. In most instances, plans negotiated by the Steelworkers Union provide for vesting only in the event of layoff or plant shutdown and require 15 years of service and attainment of age 40. In other plans vested rights are attained after reaching a given age and a specified length of service. One analysis of existing plans led to an estimate that in

[25] From the statement of Warfield G. Hobbs, president, National Council on the Aging, hearings before the Subcommittee on Retirement Income, July 12–13, 1961, Washington, D.C., p. 163.

the late 1950's perhaps 25 percent of all workers with pension coverage could obtain vested rights with 10 years of service and no age requirement or a requirement of no more than 40.

Such qualifying requirements for vesting limit its value as a means of protecting the worker's equity. In effect the worker can work for long periods for the same employer and still leave the job without retaining any pension rights. Under the common practice of deferred vesting there is the additional disadvantage of starting again to achieve eligibility for another pension plan, providing his new employer has one.

Only a minority of present-day pension plans, the multiemployer's plans, provide true "portability" of pension rights through which an individual can accumulate pension rights in the same sense that a worker can accumulate eligibility for OASDI benefits from a series of different employers.

The lack of vesting and/or the stringent requirements to attain it is a major factor in narrowing the impact of private pensions as a current and future source of retirement income.

The rapid extension of pension plan coverage will not reflect itself very completely in actual benefits provided after retirement.

Although adequate data are lacking it has been estimated that only half of the workers now covered by specific private pension plans will fulfill the requirements which would enable them to draw partial or complete benefits. A large number of workers will not remain employed long enough by a firm having a pension program to receive any or very substantial benefits from that plan.

The absence of true portability of pension rights operates as a deterrent to labor mobility. While this may be cited as an advantage to the employer and, indeed, may be a motive for establishing a pension program, its disadvantage to the worker should not be overlooked. In the present period of vast technological change, it denies him reasonable opportunity for economic advancement, as well as occupational and social adjustment. It puts a particular disadvantage on two groups of workers; those middle-aged workers who might benefit by moving out of depressed or declining areas to take jobs in new, growing industries elsewhere, but who are reluctant to do so in consideration of the pension rights they would forego; and the older unemployed worker who is put to a great disadvantage in search for a job by the apparent fear of some employers that hiring older workers means taking on a higher pension cost.

> Employers feel that they do not want to pay the higher cost of pensions and other fringe benefits, because these costs go up with age. They go up with age with their own employees, but they do not want to employ brandnew employees at a high cost for fringe benefits.
>
> I believe that if portability of pensions were to be increased, the average employer would not mind hiring a middle-aged man if he came along with a built-in pension. I think that this is a very important point.[26]

Another section of this report discusses this fear of higher pension costs and indicates that the fear is not always warranted, but for the

[26] Ibid., Warfield G. Hobbs, pp. 161–162.

point being made here, the attitude does exist and must therefore be recognized.

In spite of the cost increases that accompany the vesting of pension rights, the value of such a feature to the workers' income security in retirement pleads a strong case for its encouragement.

The feasibility of legislative or administrative action requiring companies to provide for the vesting of pension rights by eliminating tax deductions on funds paid out or set aside by private pension plans that do not provide for vesting should be given serious thought.

Constant Purchasing Power Bonds

Witness after witness at our hearings called attention to the inroads which inflation has made in their retirement incomes.

Adjustment to changes in the value of the dollar can be made relatively quickly for those persons who share directly in rising productivity through their earnings. But for retired persons who can no longer count on earnings, the adjustment has all too often had to come in the reduced amounts or different kinds of goods and services they could purchase and in their level of living.[26a]

For persons already faced with retirement, any adjustment of income to price rises must necessarily come primarily through the social security program. But for future generations of retirees, an additional source of protection that offers promise is a "constant purchasing power" retirement income bond.

Government bonds redeemable upon retirement at a value adjusted to any intervening increases in the cost of living would help to meet the gaps left by inadequate social security benefits and limited private pension plans. At present, there is no low-risk inflation hedge available to the public. Individual savers, pension funds, and other investors can obtain a measure of protection against inflation by investing in common stock. These investments are subject to other risks, however, which many savers may not wish to assume. Furthermore, the purchase of stock equities is not always a feasible course for persons in the lower or middle economic brackets.

The 1959–61 Subcommittee on Problems of the Aged and Aging therefore suggested that the Federal Government issue bonds which would be available for purchase by individuals, pension or profit-sharing plans, and life insurance companies with reserves for such plans, and which would, if held to maturity, be a means for achieving or maintaining constant purchasing power. A bill to authorize the issuance of such bonds by the Secretary of the Treasury was introduced in 1960 by Senator McNamara, together with Senators Clark and Randolph (S. 3684), and in 1961 by Senator McNamara (S. 2181). On the latter occasion, Senator McNamara stated:

> The only criticism I have heard about my proposal is that it might aggravate an inflationary trend, but it should be pointed out that anything that encourages increased savings can actually put a brake on inflationary pressures. Besides,

[26a] In 1962 the Congress recognized this fact and took action to solve the problem insofar as retired Federal employees are concerned. In enacting, as Public Law 83–793, the Postal Service and Federal Employees Salary Act of 1962, the Congress not only raised annuities by 5 percent but also provided for a cost-of-living adjustment of annuities after Jan. 1, 1964, for each year in which the price index rises at least 3 percent. It is not to be expected that many private employers can offer this same protection to their employees in the absence of such a mechanism as we here propose.

the constant purchasing bond would also reduce the rate of premature redemption of ordinary savings bonds.

A study of the feasibility of the proposed constant purchasing bond, and of the experience which other countries have had in the use of a financial instrument to provide constant purchasing power, was prepared for consideration by the Special Committee on Aging. This study, issued in August of 1961 as a committee print,[27] urges that other experts on the problems of retirement income review and comment on the proposed method of dealing with a serious problem.

Meeting the Costs of Improvements in Social Security

If the Nation is to move ahead in the areas which have been identified through our hearings as prime points of emphasis, more of our gross national product will have to be allotted to our older people.

People over 65 now make up 9.3 percent of our population. Their aggregate money income from all sources in 1960 is estimated at approximately $32 billion. This was 8 percent of our Nation's total personal income, a not unreasonable relationship to their numerical weight. But—and this is an extremely important caveat—roughly one-third of the aggregate income of the aged is derived from earnings, a source that plays no part in the incomes of at least 13 million aged persons and which plays only a supplementary role for some 3 million others. It is significant that the small numbers of full-time year-round earners, only about 1.7 million workers in 1960, accounted for almost half of the estimated total earnings of $11 billion.

Of the 1960 income of the aged, the program of old-age, survivors, and disability insurance alone contributed $8.8 billion; an additional $2.1 billion came from the retirement systems for Government employees and railroad workers; $2 billion was in the form of public assistance payments.

Together, the social insurance and related programs and public assistance paid out $12.9 billion to persons over age 65, most of whom are retired and primarily dependent on these sources for income maintenance. These payments amounted to 2.6 percent of 1960 gross national product.

The committee believes that the country can afford more than this. We also believe that our social security system is the best method of channeling our Nation's resources into an effort to improve the well-being of the aged.

The workers of this country have repeatedly expressed their willingness to pay higher social security taxes in order to assure adequate protection for their old age. In fact, organized labor has shown an increasing willingness to sacrifice higher wages now in order to purchase long-range security through higher retirement pensions and other fringe benefits which help to iron out the unevenness of the usual lifetime income cycle.

Our social security program has earned the respect and confidence of the American people. Attempts to undermine the program are likely to serve only to confuse and not to impress the average listener. For example, at one of our town meetings, the audience was bewildered by the argument that the social insurance program is "not a funded

[27] "A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income," Aug. 31, 1961.

program under which your own tax dollars are set aside for your own benefit," that it is a tax on payrolls to pay the costs of benefits for our present aged and not insurance at all. One of our witnesses, rising above the debate over semantics initiated by "that young doctor who spoke and said that social security was simply a tax," said: "It may be simply a tax but it results in an insurance because it does insure a great many old people of at least food and a living."

Nor did they seem overly impressed by charges occasionally advanced at our field hearings to the effect that the social security system is socialistic:

"The question that comes to my mind," said one town meeting witness, "is: Why a fund developed locally through a church, or community, or State is less socialistic than those of the Government, if they did it? That seems to be the opinion, and that is what is waved in front of you all of the time, and that that is socialistic. 'Be careful, you're going socialistic.' Now, where is the difference, whether the fund is raised locally by a few people, or by the whole community, and made a standard affair?"

Most of the people who spoke out at our town meetings were senior citizens. But there were also younger people who expressed their willingness to pay more social security taxes now, so that their own futures would be more secure or so that their aged parents could have adequate protection currently.

"I am one of the younger people that has a family to support," one of our townhall speakers said. "I would be willing to have it taken out for social security to take care of them and I feel most of the people feel the same way."

Another referred to our economy's increasing dependence on credit and credit cards, saying:

> Actually, we are not looking for credit cards or handouts when you pass a social security bill. And those of us who are working, have the ability to work, are willing to put in enough money to take care of the elderly people on pension now and take care of ourselves later. It is not a question of a credit card or question of handouts. It just is a question that we have pooled our resources to pay ourselves when we get over the age of 65. Not only do we get social security but when we get sick there is money in that fund to take care of us without our being a drain on our children and grandchildren that come afterward.

And still another argued:

> I ask you in all fairness: Who has paid more taxes in this country than the elderly? And they are still paying and paying on every item they use with no relief in sight. The younger people will not object to paying a small increase in their social security taxes if it is explained to them that they are laying away for the future. If any man or woman could know, and I mean actually know, not like it is now, that, when they reach the age of retirement, they would get a substantial social security benefit check, that would be sufficient to keep them the rest of their days in at least a decent living condition, is there any reason to believe they would object to such a plan?

> We buy insurance for this very purpose and strain ourselves to meet the monthly insurance policy payments. Well, why not pay it into the Government social security fund, which in itself is an insurance for old age. There are many figures by private firms and the Government itself to show any person must have at least from $40 to $50 a week to just meet their everyday expenses under our present economy, and yet we ask our elderly of this Nation, who are its backbone, to live on this much each month.

During the course of our hearings, we have again listened to the plea: "Don't kill the goose that lays the golden eggs," reminiscent of the cries of the early thirties at the inception of social security and before our social insurance system had become part and parcel of the American way of life. Our committee would be remiss, indeed, if, in carrying out our charge to recommend improvements in the economic, social, and health conditions of our aged population, we recommended a course of action that would do immediate or long-range damage to our economy. We have faith, however, in the ability of our economy to expand and to provide adequately for all our people, young and old, now and in the future.

We are well aware of the fact that the social security tax rate now in the law is scheduled to rise to 4⅝ percent each on employers and employees by the year 1969. Repeatedly, during the hearings, this was referred to as a tax rate of more than 9 percent, implying that it fell solely on the worker. We do not question the fact that the tax paid by the employer is part of his cost of business and can frequently be passed on to the consumer of his goods. But to the extent that this tax, too, falls ultimately on the worker, should that not give the worker a major voice in determining whether the program should be improved and expanded?

We were told that improvements in the program would result in a burden so intolerable as to cause future workers to revolt—that with the addition of health benefits "the taxes required could then become so burdensome as to jeopardize the present social security cash benefit program." The social security tax was referred to as "the poor man's tax, and I think it is because he actually has to put 5 percent of his income into social security, the same as the high executive earning $50,000 a year."

We are not impressed by attacks like these, intended as they are to undermine public confidence in a system that has been repeatedly scrutinized and judged sound in its financing. We would, nevertheless, call attention to the recommendation of our predecessor subcommittee that the maximum earnings base which is taxed and credited for social security benefits be raised "to at least $6,000." [28] Such an increase would not only provide larger benefits for future beneficiaries as a result of crediting their higher earnings, but it would provide additional revenue to the system which could be used for other improvements without necessitating an increase in the contribution rate. In terms of the level premium, the increase in net income to the

[28] "Action for the Aged and Aging," a report of the Committee on Labor and Public Welfare made by its Subcommittee on Problems of the Aged and Aging, together with minority views; a resolution authorizing a study of the problems of the aged and aging, 87th Cong., 1st sess., Rept. 128, Mar. 28, 1961, p. 77.

system would amount to one-third of 1 percent of payroll if the base were raised to $6,000 and one-half of 1 percent if raised to $7,000.

We would also call attention to the possibility of reducing the "poor man's tax"—or assuring that it will stay within limits he is willing to pay—by providing for a Government contribution to the system (provision for such a contribution was formerly included in the Social Security Act, but never used). With appropriate improvements in the social insurance program, it would seem reasonable to channel into this program Federal funds that are now being used to assist States and localities in financing programs of old-age assistance and medical assistance for the aged. To legislate improvements in the social insurance program solely on the presumption that general revenues might eventually be used to share the costs would undoubtedly be challenged as fiscally irresponsible, despite the fact that these costs can be calculated with a reasonable degree of accuracy. In actuality, however, is this not more fiscally responsible than our present method of providing the States with a blank check on the Federal Treasury, with no safeguard to assure that these Federal funds are used to improve the welfare of the aged and not just to relieve the States of costs already carried?

State Tax Benefits for the Aged [29]

In presenting this section of our report, the committee believes it important to emphasize the fact that favored tax status or preferential tax treatment is of little meaning to those of the elderly who have minimal or no taxable income at all—as for example, the more than 14 million older persons who pay no Federal income taxes. Nonetheless, while a special tax benefit does not, of course, raise the level of income, it does represent an increase in spendable income and, hence, is relevant to a discussion of the income levels of older people. This section of our report, therefore, attempts to set forth the special tax treatment allowed (1) the aged in the various States,[29] and (2) the younger taxpayer who supports an aged dependant.[29a]

It examines tax provisions in all the States that levy an individual income tax to determine the benefits granted in the form of liberalized medical deductions and personal exemptions. It also lists several examples of other benefits allowed in the several States.[29b] No comprehensive analysis, however, was made of these other benefits.

The information in this section was compiled over the past year and does not necessarily reflect the situation as of a given moment. However, all of the information reflects the status of legislation as of the beginning of 1961 with more recent developments taken into account in several cases.

While the committee believes that the Federal Government should give prompt and favorable consideration to easing the tax burden

[29] Appendix F contains a summary of Federal tax provisions for older persons.

[29a] The committee gratefully acknowledges the able assistance of the Economics Division of the Legislative Reference Service of the Library of Congress in the preparation of this section of our report. Mr. Harold A. Kohnan, analyst on taxation and fiscal policy, was particularly helpful.

[29b] The basic source of this information was the Commerce Clearing House State Tax Reporter.

borne by older people,[30] it makes no recommendation as to what action the separate States should take. We present the following in the hope that it will prove of value to people in the various States who are concerned with tax policies and the elderly.

I. STATES WHICH LEVY AN INDIVIDUAL INCOME TAX

This report considers the following 35 States as levying an individual income tax:

Alabama	Kentucky	North Carolina
Alaska	Louisiana	North Dakota
Arizona	Maryland	Oklahoma
Arkansas	Massachusetts	Oregon
California	Minnesota	South Carolina
Colorado	Mississippi	Tennessee
Delaware	Missouri	Utah
Georgia	Montana	Vermont
Hawaii	New Hampshire	Virginia
Idaho	New Jersey	West Virginia
Iowa	New Mexico	Wisconsin
Kansas	New York	

This list includes Indiana which levies a gross income tax. Also included in the list are New Hampshire and Tennessee which levy an income tax on interest and dividend income only.

II. LIBERALIZED MEDICAL DEDUCTIONS

Of the 35 States which levy an individual income tax, 17 of them do not allow a special deduction to the aged taxpayer or spouse for medical expenses. The fact that a State does not give preferential treatment to the aged does not necessarily mean, however, that the State is less liberal in allowing medical deductions for them than in another State that extends special deductions. For example, some States allow full deductions for medical expenses for everyone (e.g. Colorado), or allow all deductions over a small minimum (e.g., Kansas, which allows all deductions over the first $50 for everyone).

Eighteen of the States which impose an individual income tax allow liberalized deductions of medical and dental expenses incurred by the taxpayer or spouse.

Most of the States allow the taxpayer to deduct medical and dental expenses incurred on behalf of an aged parent. Generally the law provides that the taxpayer may deduct expenses incurred for any dependent, as defined for purposes of personal exemptions (or dependency credit). An aged parent is usually within the scope of the definition. Some of the States allow a liberalized deduction for expenses incurred on behalf of a dependent who is an aged parent. A few of the States do not allow any deductions for medical expenses. Accordingly, a taxpayer who supports an aged parent will not be

[30] The committee would emphasize the fact that a tax cut for the elderly cannot in any logical sense be considered an acceptable substitute for a program of hospital insurance based on the social security mechanism. First, because at most, only the one in five who pay taxes would benefit by it and, equally important, because while a tax cut might give each of the elderly benefiting by it some tens of dollars, illness does not strike equally and to those it does strike the costs may run into the thousands of dollars.

allowed a deduction for medical expenses incurred on behalf of the parent.

The following table lists separately those States which do and those which do not allow liberalized deductions for medical and dental expenses incurred by or on behalf of the aged.

States which do allow a liberalized deduction:

Alaska	Idaho	New Jersey
Arizona	Iowa	New Mexico
California	Kentucky	New York
Delaware	Maryland	Vermont
Georgia	Massachusetts	Virginia
Hawaii	Montana	West Virginia

States which do not allow a liberalized deduction:

Alabama	Mississippi	Oregon
Arkansas	Missouri	South Carolina
Colorado	New Hampshire	Tennessee
Kansas	North Carolina	Utah
Louisiana	North Dakota	Wisconsin
Minnesota	Oklahoma	

Some of the States which allow liberalized deductions follow the general rules of the Federal income tax. These States are:

Alaska	Montana	New York
California	New Jersey	Vermont
Massachusetts	New Mexico	West Virginia

Most of these States, however, provide that they follow the Federal income tax law as of a certain date. In these cases the recently enacted law, Public Law 87–863, which allows an increase in the maximum medical deductions for taxpayers who are aged and disabled probably will require special legislation in those States to make their laws strictly comparable to the Federal law.[31]

Many of the other States that allow a liberalized medical deduction follow quite closely the provisions of the Federal law. Excluding the nine States listed above, each of the States which allow liberalized deductions is briefly discussed below.

Arizona.—Taxpayers in general are limited to maximum deductions for medical expenses. The deductions are $2,500 and $5,000, respectively, for individuals and married couples.

Individuals who are at least 65 years of age may deduct (1) all payments for medical care of the taxpayer and spouse, and (2) medical care payments for dependents, subject to the $2,500 and $5,000 limitations.

Delaware.—In general, medical expenses of the taxpayer, spouse, or dependent are deductible only to the extent such expenses exceed 5 percent of gross income. However, if either the taxpayer or spouse is 65 or older, the entire amount of noncompensated expenses for medical care of the taxpayer of his spouse may be deducted plus the amount by which such expenses for the care of dependents exceed 5 percent of the gross income.

[31] This law increased maximum deductions applicable to all taxpayers.

Georgia.—In general, taxpayers may deduct only those medical expenses which exceed 3 percent of income. They are limited to maximum deductions of $5,000 for single persons and $10,000 for married couples and heads of households.

The 3-percent rules does not apply to expenses paid by a taxpayer or his wife in the following instances: (*a*) for himself and his wife if either is 65 years or over, and (*b*) for a dependent who is 65 years of age or over and who is the mother or father of the taxpayer or wife.

Also, if the taxpayer or wife is disabled and 65 or over, they may qualify for an increased maximum limitation on the amount deductible.

Hawaii.—Deductions for the aged follow the general pattern of the Federal tax law, with some variation in the maximum amounts deductible.

In Hawaii taxpayers over 65 are generally limited to the maximum deductions applicable to taxpayers under 65 namely, to $2,500 multiplied by the number of exemptions other than the additional exemption for old age. If the taxpayer or spouse is at least 65 and disabled the maximum limitation is $15,000.

Idaho.—The Idaho law follows the Federal law in its application of the 3-percent provision.[32] The amount deductible for taxpayers is limited to $5,000 for single individuals and $10,000 for married couples. If either the taxpayer or spouse is disabled and 65 or over the taxpayer may qualify for increased maximum limitations to the deductions.

Iowa.—Treatment of medical expenses follows the Federal income tax, with apparently one exception. Iowa tax instructions state that amounts spent by the taxpayer for a dependent 65 or over are fully deductible (i.e., the expenses do not have to be reduced by 3 percent of adjusted gross income). The Federal law waives this 3-percent rule for aged dependents only if they are parents of the taxpayer or spouse.

Kentucky.—The 3-percent provision which is generally applicable to taxpayers under 65 years of age is not applicable to medical expenses incurred for taxpayer and spouse if either is at least 65. The amounts spent for dependents, however, are limited to the amount in excess of 3 percent of the taxpayer's income.

Maryland.—If either the taxpayer or spouse is 65 years or over, the amount deductible is not restricted to the excess over 3 percent of adjusted gross income, as is the case for taxpayers under 65.

The maximum deductions and the amount deductible for medicines are the same as for taxpayers under 65.

Virginia.—Deductions, with certain maximum limitations are allowed generally for medical expenses which exceed 5 percent of adjusted gross income. If a taxpayer or his spouse is 65 or older the entire amount of medical expenses for themselves may be claimed plus that portion of expenses for dependents which exceeds 5 percent of income, subject to maximum deductions which are generally appli-

[32] Thus, taxpayers generally are allowed to deduct medical expenses that are in excess of 3 percent of their income. Also, the 3-percent provision does not apply to expenses paid by a taxpayer or spouse for (1) himself and his wife if either is 65 or over, and (2) a dependent who is at least 65 and who is the mother or father of the taxpayer or his spouse.

cable. (This follows generally the Federal law except that the Federal law uses 3 percent instead of 5 percent.)

In general, maximum deductions are limited to $1,250 for each exemption with a maximum total deduction of $5,000. In the case of a taxpayer who is disabled and at least 65 and/or a spouse disabled and 65 or over, the same amounts and provisions of the Federal law existing prior to enactment of Public Law 87–863 apply.

III. ADDITIONAL PERSONAL EXEMPTIONS

Of the 35 States which levy an individual income tax, 22 States allow an additional exemption for an aged taxpayer and spouse. The age at which the taxpayer qualifies for the additional exemption is 65. The following table lists separately the States (1) which do allow an additional exemption, and (2) those which do not allow an additional exemption.

Additional exemption allowed:

Alaska	Kentucky	Oregon
Arizona	Maryland	South Carolina
Colorado	Minnesota	Vermont
Delaware	Montana	Virginia
Georgia	New Jersey	West Virginia
Hawaii	New Mexico	Wisconsin
Idaho	New York	
Kansas	North Dakota	

No additional exemption allowed:

Alabama	Massachusetts	Oklahoma
Arkansas	Mississippi	Tennessee
California	Missouri	Utah
Iowa	New Hampshire	
Louisiana	North Carolina	

In most of the States which allow an additional exemption the amount of such exemption is equivalent to the regular personal exemption that is allowed a single taxpayer (or a married taxpayer filing separately). The most common amount is $600, as under the Federal income tax law. In a few States (e.g., Georgia) the additional exemption is less than that allowed a single taxpayer.

A few States (e.g., Kentucky) allow a tax credit—that is, a deduction from the taxpayer's tax liability—as distinguished from a deduction from gross income. Also to be noted is that several States (e.g., Mississippi), which do not provide for additional exemptions because of age, allow a very high exemption to all taxpayers.

In most of the income-tax States a taxpayer is allowed a personal exemption (dependency credit or exemption) for an aged dependent. In a few States (e.g., Mississippi) no exemption is allowed for any dependent regardless of age. In one State the taxpayer is allowed a dependency exemption for an aged person only if that dependent is incapable of self-support. Generally the law provides that the taxpayer must provide more than half the support of the person, and that person must be blood-related. In about a third of the States the exemption is less in amount than the exemption allowed to the single taxpayer (or to the married taxpayer filing a separate return). In

some of the States an unmarried person who supports an aged relative may take a head-of-household exemption, which amounts to more than a single person's exemption plus the dependency exemption.

In only one State, Maryland, may a taxpayer obtain an additional exemption in addition to the regular dependency exemption, for an aged dependent. Thus, a married couple supporting an aged mother in Maryland would obtain two exemptions on behalf of the aged parent.

IV. EXAMPLES OF OTHER SPECIAL BENEFITS

Other special provisions which we have identified as benefiting the aged are the following: California allows a retirement income credit similar to that provided in the Federal income tax law.[33] In Hawaii, individuals who establish residence in Hawaii after the age of 65 are subject to tax on income from Hawaii sources only.

Some States provide a limited exemption from the property tax. In Indiana, for example, an exemption of $1,000 of the assessed value of a person's property is allowed if (1) the person is 65 years of age or over, (2) the income of the person (and spouse) does not exceed $2,250 a year, (3) the value of the property does not exceed $5,000, (4) the person lives on the property, and (5) the person receives no other exemption from the property tax. Up to $2,000 of real estate occupied by a person over 70 years of age is exempt from the property tax in Massachusetts if the property has been occupied by the person for at least 10 years and the person's estate (excluding certain items) does not exceed $8,000.

[33] The provision, however, does not reflect the change recently enacted in Federal Public Law 87–876, signed Oct. 24, 1962.

CHAPTER III. DEVELOPMENTS IN HOUSING, HOMES FOR THE AGED, AND NURSING HOMES

A. Housing Needs and Housing Programs

The foundations of present Federal programs in housing for the elderly were laid down in the Housing Acts of 1956 and 1959. These, essentially, were modifications specifically for the elderly of programs well established and functioning in other housing fields.

The special committee's predecessor subcommittee in its report, "The Aged and Aging in the United States: a National Problem," published in February 1960, called attention to the magnitude of the housing need at the low and lower middle income levels which include a great majority of the elderly population. Specific recommendations were made for increases in public housing units authorized, such increases to be earmarked for units for elderly tenants, and an increase in appropriations authorized for the direct loan program established by section 202 of the Housing Act of 1959.

The Housing Act of 1961 expanded and improved housing programs for senior citizens, substantially carrying out the subcommittee's recommendations and added other important features to the legislation. The Senior Citizens Housing Act of 1962 further expanded the authorization for appropriations for direct loans and established new programs in the Farmers Home Administration to aid in improving the housing of elderly citizens in rural areas.

Today we have a total of 10 Federal programs to stimulate the construction or improvement of housing for elderly citizens. Seven of these programs are directed specifically to housing for the elderly. Three others have an indirect bearing on the supply of good housing for older citizens and have a greater potential for assisting the elderly than is now being realized. Each of these is discussed on the following pages and a chart outlining the entire group of programs appears on pages 106 and 107.

BRIEF DESCRIPTION OF THE PROGRAMS

Public housing for the elderly

The low-rent public housing program was authorized by the Congress in the Housing Act of 1937 as a Federal aid to communities through which they might provide safe, decent, and sanitary housing for low-income families who cannot afford standard private housing. The dwellings are planned, built, and operated by local housing authorities and financed through bonds issued by the local authorities. The bonds are repaid out of net rental income earned by the authority with deficits made up from Federal funds appropriated for that purpose.

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Low-rent public housing has been available to many low-income older families from the inception of the program. However, two changes made in the law by the Housing Act of 1956 greatly expanded its usefulness in this respect. Those amendments extended eligibility to occupy public housing to single elderly persons as well as families, and authorized the design and construction of public housing units especially for the elderly. The special design features which make buildings and apartments more suitable for elderly people usually result in increased construction cost, and in 1961 the Congress eased the construction cost limitations on special units for the elderly.

Since elderly individuals or families typically are in the lowest income groups and cannot afford to pay even as much rent as other low income public housing families, in 1961 the Congress also provided an additional subsidy to local housing authorities of up to $120 per year for each elderly family housed. This subsidy serves to bring the average income per unit in a project up to the level that it would be if a normal distribution of age and income existed in the project.

In addition, the Housing Act of 1961 authorized the Public Housing Administration to contract with local housing authorities for approximately 100,000 additional units. While no part of this 100,000-unit authorization was specifically set aside for the elderly, as had been recommended by the Subcommittee on Problems of the Aged and Aging, the experience has been that an increasing proportion of the new projects planned by local housing authorities are for elderly tenants. About 54 percent of the new units approved by the Public Housing Administration during fiscal year 1962 were for the elderly.

As of December 31, 1960, the Public Housing Administration had executed annual contributions contracts for 18,348 units. In 1961, 11,781 additional units and in 1962 a total of 12,076 more units were placed under annual contributions contracts. Total estimated units (cumulative) as of December 31, 1962, were 42,205 or an increase in 2 years of 23,857 units—approximately 130 percent. Thus, in the past 2 years units placed under annual contributions contracts were 5,509 more than the total of the previous 5 years combined.[1]

By the end of 1962, 19,086 units of low-rent public housing especially designed for the elderly had gone under construction, of which 7,937 units were completed by the end of 1962. In addition to these units especially for the elderly, senior citizens occupy public housing units available to low-income persons of any age. It is estimated that, in total, more than 116,000 elderly people now live in public housing.

The median income for senior citizen families moving into public housing in 1961 was $119 per month. The median gross rent including all utilities was $31 per month. Since more than half of all the senior citizen households in the Nation have incomes below this median, it is clear that the public housing program will have to fill an even larger share of this vast and urgent need than has been contemplated up to now if the need is to be met in any substantial degree.

Mortgage insurance—rental housing

In 1959 the Congress decided to support a program designed to encourage private financing of profit-motivated builders as well as nonprofit and local governmental organizations interested in building

[1] Source: HHFA, Office of Housing for Senior Citizens.

new rental housing for people over 62 or in rehabilitating older buildings for that purpose. Under the new section, section 231 of the National Housing Act, the Federal Housing Administration is authorized to insure lenders against losses on mortgages used for construction or rehabilitation of rental accommodations for older persons. A rental housing project may be eligible for mortgage insurance if it contains eight or more units of new or rehabilitated housing specifically designed for occupancy by persons 62 years of age or older.

The amount of an insured mortgage may not exceed—

(1) $12.5 million if executed by a private borrower or $50 million if executed by a governmental body.

(2) For one-story buildings, $2,250 per room or $9,000 per dwelling unit if the number of rooms in the project is less than four per dwelling unit; for elevator buildings, $2,750 per room or $9,400 per dwelling unit if the number of rooms in the project is less than four per dwelling unit.

These per room limits for either type of building can be exceeded by amounts prescribed by the FHA in localities designated as high-cost areas. The additional amount can go as high as $1,250 per room, permitting a maximum insurable cost of $4,000 per room for a high-rise building in a high-cost area.

Where the sponsoring group is a local governmental agency or a private nonprofit organization, the FHA will insure a mortgage for as much as 100 percent of estimated replacement cost, i.e., actual cost of construction plus market price of site and related costs if the construction is new. Where the project is one of rehabilitation of an existing structure, the FHA mortgage insurance will be based on 100 percent of the estimated value, i.e., estimated long-term investment value taking into account age, condition, etc., of the existing facility.

Where the sponsor is a private individual or organization engaged in a profitmaking operation, the FHA will insure mortgages up to 90 percent of estimated replacement cost on new construction and 90 percent of estimated value for a rehabilitated building.

The mortgage loan can be repaid over a number of years (up to 40) approved by the FHA and can bear interest at not more than the rate prescribed by the FHA. Currently, the rate is 5¼ percent plus one-half of 1 percent mortgage insurance premium.

It is important to emphasize that this program is based on insurance of mortgages rather than direct loans. The mortgagor must secure his loan from a private lending institution which in turn can seek mortgage insurance from the FHA. However, the availability of FHA mortgage insurance makes it much easier to obtain financing for such projects.

As of December 31, 1960, the FHA had issued commitments for mortgage insurance under sections 231 and 207[2] for a total of 9,578 units equaling $94.9 million. By December 31, 1962, this total had risen to 25,976 units amounting to $298.3 million of mortgage insurance. Thus the activity in these 2 years had more than tripled in dollar volume, and about 2½ times in numbers of units. Activity in calendar 1962 was at a rate approximately 17 percent higher than that of calendar 1961.

[2] The mortgage insurance program for general multifamily rental housing.

Total construction starts through December 31, 1962, amounted to 22,317 units of which 9,496 units have been completed. Construction starts for 1962 alone were equal to almost one-half of all units put under construction since the inception of the program.[3]

The direct loan program

The public housing program provides low-rent housing for elderly tenants of low income. The mortgage insurance program, on the other hand, produces housing for which rents are much higher and which a comparatively small percentage of our senior citizens can afford. The Congress sought to fill in some of this gap with a new program of direct loans to nonprofit organizations interested in sponsoring new rental housing for the elderly.

The new program, established by section 202 of the Housing Act of 1959, is administered by the Community Facilities Administration and is for persons 62 years of age and older. Loans may be made for terms up to 50 years. The current rate of interest is 3½ percent.

The purpose of this program is to stimulate the provision of suitable housing for older persons whose incomes are too high for public housing but not sufficient to meet the cost of good housing in the conventional, completely private market. The legislation was amended in the Housing Act of 1961 to include as eligible sponsors consumer cooperatives and public bodies other than local public housing authorities. In addition, the total amount the Federal Government might lend was raised from the original $50 million authorized in 1959 to $125 million. The Senior Citizens Housing Act of 1962 again increased the maximum amount to the present level of $225 million.

A nonprofit organization applying for a loan under section 202 of the Housing Act of 1959 must be so organized that it is assured of remaining in existence at least as long as the number of years needed to pay off the loan for which it is applying. Therefore, most sponsoring organizations, other than public governmental bodies, have ties with labor, fraternal, church, and civic groups of considerable stature and frequently are related to some regional or national organization.

At the end of calendar year 1960, the program had been in operation only 6 months. At this time there were 285 units under fund reservation for Federal loans amounting to $2.8 million. In 1961 an additional 3,130 units were under fund reservation for $33.8 million. Figures reported through December 31, 1962, show an additional 5,395 units under fund reservation for that one year with a dollar value of $59.8 million.

Thus, the total number of units for which loan agreements had been executed or fund reservations made at the end of calendar year 1962 was 8,814 units for a total dollar volume of $96.4 million. Net fund reservations in calendar 1962 alone were 76 percent higher than the number of units reserved in calendar 1961.

By the end of 1962, 2,113 units had been placed under construction for a total dollar volume of $24.2 million. Only 7 projects had been completed by the end of 1962, but approximately 20 were nearing completion.[3]

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[3] Source: HHFA; Office of Housing for Senior Citizens.

Mortgage insurance on sales to the elderly

Diminished income and earning power as well as reduced life expectancy have made it very difficult for retired people who wished to buy a home to obtain mortgage financing. A fourth provision of housing law is designed to assist older persons who desire and are able to own their own homes.

Through amendments to section 203 of the National Housing Act made by the Housing Act of 1956, liberalized methods to assist in the financing of such homes were provided. The FHA is authorized to insure a lender against losses on a mortgage for housing being purchased by a person 62 years of age or more, and it is possible for friends, relatives, or even a corporation to make the downpayment instead of the elderly purchaser himself.

In addition, if an older person is unable to qualify as an acceptable mortgage risk either because of age, physical condition, or financial position, it is permissible for a third party to become a cosigner of the mortgage. In this way, a son or daughter, other relatives, or friends can, by signing the note with an elderly person, assure the financial acceptability of the older person to a lending institution.

Housing for the elderly in rural areas

All of the programs described so far are available to help produce housing for older people anywhere in the country—in rural as well as urban areas. However, the activities of the Housing and Home Finance Agency under these programs have tended to be concentrated in cities and have not been very well known or well understood in rural areas. Therefore, the Congress established through the Senior Citizens Housing Act of 1962, several new housing aids for senior citizens to be administered by the Farmers Home Administration in the Department of Agriculture. Since the Farmers Home Administration programs are well established and are well known to residents in rural areas, it is hoped that they will use these new programs which extend to them the same kinds of assistance that have been available to the elderly in cities through the programs of the Housing and Home Finance Agency.

The existing Farmers Home Administration program of loans for new construction on farms and in rural nonfarm areas was amended by the Senior Citizens Housing Act of 1962, to give the elderly certain special advantages. First, persons over 62 years of age are permitted to buy existing houses as well as to build new homes. Second, cosigners on mortgages for elderly purchasers are permitted where necessary to assure repayment which is not permitted in the case of younger applicants for loans. Third, both the cost of land and the dwelling may be covered by the loan, while younger borrowers must own the land on which they plan to build before applying for a loan.

An additional $50 million in loan funds was authorized to be earmarked exclusively for loans to the elderly.

The act also set up a new program of direct loans by the Farmers Home Administration to private nonprofit corporations and consumer cooperatives to build moderate cost rental housing for the elderly. This program is similar to the direct loan program under section 202 of the Housing Act of 1959, administered by the Community Facilities Administration which was described earlier. Loans may be made

for a period of up to 50 years and have an interest rate which currently stands at 3½ percent. A limit of $50 million was placed on the total amount of loans which the Farmers Home Administration could make under this new program.

The Senior Citizens Housing Act of 1962 also established a mortgage insurance program in the Farmers Home Administration to stimulate private loans to builders and organizations interested in developing rental housing for the elderly in rural areas. This program is similar to that administered by HHFA under section 231 of the Housing Act. These mortgages may be for terms up to 40 years and carry an interest rate of 5¼ percent.

OTHER PROGRAMS WITH POTENTIAL APPLICATION TO HOUSING PROBLEMS OF THE ELDERLY

Moderate income housing, section 221(d)(3)

A new section of the National Housing Act with important potential for the elderly was added by the Housing Act of 1961. Section 221(d)(3) is a tool to help meet the needs of moderate income families, including those displaced by urban renewal or other governmental programs and in need of housing in a new location. Because they tend to remain behind in old and deteriorating urban neighborhoods while younger people are moving out, a greater proportion of older persons than younger persons are affected when communities decide to wipe out rundown neighborhoods through urban renewal projects.

Loans under section 221(d)(3) are available to cooperatives and other nonprofit groups for the development of housing for moderate income families. Such loans now carry an interest rate of 3⅛ percent and a waiver of the one-half percent FHA insurance premium. These terms permit substantial reductions in financing costs and hence in rent levels.

The usefulness of section 221(d)(3) for the elderly is greatly impaired by its present limitation to family units. Census figures show that about 22 percent of the older population live alone or with nonrelatives. A large proportion of these are widowed individuals. The committee believes that serious consideration should be given to amending section 221(d)(3) to permit its use to build housing for elderly persons as well as for families.

New FHA rehabilitation loan insurance programs

The Housing Act of 1961 established two new FHA tools to assist the private financing of neighborhood improvement. Section 220(h), confined to approved urban renewal areas, provided very flexible authority to insure supplementary loans to finance property rehabilitation, based on any type of security acceptable to the Commissioner. At the same time, the 1961 act liberalized the amount of the mortgage on a particular property which was eligible for mortgage insurance. Under the formula provided in the 1961 act, these loans could be based on the value of the property as is, taking into account the proposed urban renewal improvements to the neighborhood, plus the cost of repairs for which the mortgage loan was obtained.

The second new approach to home improvement passed in the 1961 Housing Act was section 203(k). Under this authority, FHA was authorized to insure supplementary loans, secured by liens acceptable to the Commissioner, to finance major property improvements outside of urban renewal areas. These loans could be for amounts up to $10,000 or for an amount which, when added to any existing outstanding debt, would not exceed the loan which would be insurable under section 203(b). The loans may be for a term as long as 20 years.

These two new insuring authorities represent important and needed additions to the authorities avaliable to finance neighborhood improvement and to help conserve our vast and valuable stock of existing urban housing. However, activity under these programs has been very slow up to the present time.

Potential for assistance to the elderly.—To the extent that these approaches tend to conserve or rehabilitate older and, typically, lower cost structures the supply of acceptable housing at rents older people can afford is augmented. For the elderly homeowner, such programs may assist in the maintenance of his home in livable condition and delay for many years his having "a housing problem."

Programs directed toward the conservation and rehabilitation of the existing supply of low-cost urban housing are of great importance to the housing conditions of our older citizens and merit increased emphasis in our total battery of programs. The committee developed in its 1961 hearings the fact that many potential elderly users of the programs, because of their low, fixed incomes, are unable to make the payments which would be required to amortize loans. Recommendations were made on this point in the report of the Subcommittee on Housing for the Elderly, discussed here on page 108. Implementation of these recommendations would be a useful step, but further study should be given to the reasons for the small impact these programs are now having, and to finding ways of strengthening the programs and making them more usable to elderly persons with low, fixed incomes.

SUMMARY OF PRESENT PROGRAMS

The chart on pages 106 and 107 lists the programs described in this section and essential facts on their purposes and administration.

Summary of direct and indirect Federal aids for housing the elderly

PROGRAMS FOR HOUSING SPECIFICALLY FOR THE ELDERLY

Program	Statutory authority	Purpose of the program	Available to—	Interest rate	Responsible agency [1]
(1) Public housing	Housing Act of 1937, as amended by Housing Acts of 1956 and 1961.	Specially designed low-rent housing for persons 62 years of age or over who cannot afford other standard housing.	Local housing authorities		Public Housing Administration.
(2) Mortgage insurance for multifamily rental housing.	Sec. 231 of the National Housing Act, as amended by Housing Act of 1959.	Assistance in private financing of new or rehabilitated rental housing for occupancy by persons 62 years of age or older.	Private profitmaking businesses, nonprofit organizations, and governmental agencies.	5¼ percent plus ½ percent insurance premium.	Federal Housing Administration.
(3) Mortgage insurance for multifamily rental housing in rural areas.	Sec. 515(b) of Housing Act of 1949, as amended by Senior Citizens Housing Act of 1962.	Same as (2) above in rural areas or communities with population of 2,500 or less.	Any individual, partnership, corporation, or trust acceptable to the Secretary.	do	Farmers Home Administration of the Department of Agriculture.
(4) Direct loans for rental housing for elderly.	Sec. 202 of Housing Act of 1959, as amended by Housing Act of 1961 and Senior Citizens Housing Act of 1962.	Provides long-term, low-interest loans to build housing for persons 62 years of age or over who can afford higher rents than public housing but less than rents for comparable, completely private housing.	Cooperatives and other nonprofit organizations and certain governmental agencies.	3½ percent	Community Facilities Administration.
(5) Direct loans for rental housing for the elderly in rural areas.	Sec. 515(a) of Housing Act of 1949, as amended by Senior Citizens Housing Act of 1962.	Same as (4) above for elderly persons in rural areas or communities with population of 2,500 or less.	Consumer cooperatives and other nonprofit organizations.	3½ percent	Farmers Home Administration of the Department of Agriculture.
(6) Mortgage insurance for sales housing.	Sec. 203 of the National Housing Act, as amended by the Housing Act of 1956.	Assists persons 62 years of age or over to obtain financing to build or purchase a residence.	Individual purchasers	5¼ percent plus ½ percent insurance premium.	Federal Housing Administration.

(7) Financial assistance for elderly persons in rural areas.	Sec. 501 of the Housing Act of 1949, as amended by the Senior Citizens Housing Act of 1962.	Assists elderly persons in rural areas or communities of 2,500 population or less to construct, rehabilitate or purchase a dwelling (including necessary land) through direct loans.	Elderly individuals in rural areas who are currently without an adequate dwelling.	4 percent	Farmers Home Administration of the Department of Agriculture.
PROGRAMS WITH INDIRECT OR POTENTIAL APPLICATION TO HOUSING PROBLEMS OF THE ELDERLY					
(8) Moderate income multifamily housing.	Sec. 221(d)(3) of the National Housing Act, as amended by the Housing Act of 1961.	Provides below market interest rate financing for construction or rehabilitation of rental housing for families displaced by governmental aetion and other low or moderate income families.	Cooperatives and other nonprofit organizations, limited dividend corporations, and certain governmental agencies.	3⅛ percent	Federal Housing Administration.
(9) Housing improvement loans.	Sec. 220(h) of the National Housing Act, as amended by the Housing Act of 1961.	Assists in financing of rehabilitation, or repairs for conservation of single and multiunit housing in urban renewal areas.	Property owners	5¼ percent plus ½ percent insurance premium.	do.
(10) Housing improvement loans.	Sec. 203(k) of the National Housing Act, as amended by the Housing Act of 1961.	Same as (9) above for properties not in urban renewal areas.	do	do	do.

[1] For further information on these programs, inquiries may be addressed to the agency listed in this column at Washington 25, D.C.

THE SUBCOMMITTEE ON HOUSING FOR THE ELDERLY

In recognition of the importance of housing to the welfare of older persons, the Special Committee on Aging established an ad hoc Subcommittee on Housing for the Elderly in May of 1961.

The subcommittee examined the adequacy of the supply of decent housing suitable for older persons and reviewed current efforts, both public and private, to produce such housing. In particular, the subcommittee attempted to evaluate the effectiveness of Federal programs in helping to expand the supply of suitable housing for the elderly and to determine the need, if any, for further Federal legislation.

The subcommittee conducted five hearings—a 2-day hearing in Washington, D.C., on August 22 and 23, 1961, followed by field hearings in Newark, N.J.; Philadelphia, and Scranton, Pa.; and St. Louis, Mo. In addition, some testimony on housing problems was taken in the 34 hearings conducted by subcommittees of the Special Committee on Aging in 1961 and early 1962.

Report of the subcommittee

The subcommittee issued a report in August 1962 on the results of its work in which it set forth the following conclusions and recommendations:[4]

Summary of conclusions.—(1) *Housing for the elderly is a national problem of great magnitude.*—The Nation has only begun to recognize and come to grips with it, and the problem will grow as the number of elderly persons grows from more than 17 million over 65 in 1960 to 24.5 million in 1980.

(2) *About 5 million households among the 11 million containing elderly persons, or 45 percent, need to be better housed.*—While the supply of housing is inadequate for all age groups—as indicated by the estimated 11 million substandard units still in use—a higher proportion of elderly than of any other age group live in substandard dwellings because their income is least.

(3) *Housing designed for families may be unsuitable for the special needs of elderly persons, especially those most advanced in age.*—Even among elderly persons living in "standard" housing, many are ill housed because they need housing especially designed for older persons. Such housing units should be suitable in size for single individuals or couples, easy to maintain, economical in cost, convenient to community activities and services, and incorporate certain design features which reduce the hazards to older people and enable them to maintain independent households longer than is possible otherwise.

(4) *Individual retired people differ widely in their housing needs and desires.*—Specially designed housing should, therefore, offer a range of choice, adjusting to the requirements of the older person rather than requiring him to make the adjustment to a style of living he may find objectionable.

(5) *In view of the severely limited incomes of most persons over 65, substantial improvement in the living conditions of the Nation's elderly depends heavily on Federal assistance to provide specially*

[4] Housing for the Elderly—A Report of the Subcommittee on Housing for the Elderly to the Special Committee on Aging, committee print, Aug. 31, 1962.

designed housing at reduced costs.—Present Federal programs—FHA insurance, direct Federal loans, and special public housing units—for those relatively few persons whom they serve, are of great benefit. But compared with the magnitude of the need, they have barely scratched the surface—producing a few thousand units when the need is in the millions. If the Nation is to succeed in providing decent shelter for all its older citizens, it must undertake an effort on a scale far greater than is now underway. To the extent that such Federal participation in making suitable housing available to the elderly at prices they can afford enables the elderly to carry on their own lives in their own way instead of becoming institutionalized and dependent on public charity, it will not only recognize our sense of moral obligation to our elders but may well result in financial savings.

(6) *Such an effort can hardly be undertaken as long as all of these Federal programs depend on appropriated funds which are included as budget expenditures.*—The direct loan and loan insurance programs for the elderly involve no cost to the taxpayer, and no net increase in the Federal debt. Yet through the technicalities of budget presentation these transactions are treated the same as other governmental expenditures which involve 100 percent subsidy. Either a new method of financing housing for the elderly must be found which will bring down interest rates without requiring the use of appropriated funds, or the methods of budget presentation must be changed so that repayable loans are not lumped in with outright expenditures. If banks and other financial institutions were to enter sound repayable loans on their books as outright expenditures we would regard it as absurd and they would be regarded as bankrupt. It seems to us altogether absurd for the Federal Government to continue to do so.

(7) *Even if the limits could be removed from Federal assistance, few communities are prepared to take advantage of such assistance and proceed rapidly with the design and construction of specialized housing for the elderly.*—The country needs more specialists in the field of housing for the elderly, and communities need to mobilize the resources of all organizations, both public and private, which can contribute to leadership and planning.

(8) *In order that housing for the elderly may be properly planned, much more knowledge is needed.*—Research should be of two kinds—general studies aimed at learning more about the effects of various housing arrangements on older persons and evaluating the varied projects which have been undertaken; and community-by-community studies of the shortcomings of housing for the elderly and the particular needs and desires for improved shelter expressed by the elderly themselves in each locality.

(9) *Each community should develop a plan for housing its own elderly.*—Such plans should be based on the results of both general and local research and should be directed toward enabling those who are ill-housed to move into suitable dwellings and offering a range of choice within the limits of what the elderly can afford. Such a community plan should be an element of, and consistent with, the community's comprehensive physical plan.

(10) *Urban renewal has worked particular hardships on elderly persons.*—This is true both because they are heavily concentrated in renewal areas and because as a group they are less adaptable and hence

suffer more from sudden and enforced change in their living arrangements. Every possible step should be taken to soften the impact of urban renewal on older people. Certainly any community planning for an urban renewal project should include special consideration to the suitable rehousing of elderly residents.

Principal recommendations.—The subcommittee offered the following recommendations, which were developed in more detail in the remainder of its report.

(1) *Expansion of Federal programs.*—Federal assistance under existing programs for housing for the elderly—FHA insurance, direct loans, and special public housing units—should be expanded as rapidly as communities are prepared to take advantage of these aids. The authorization for the direct loan program should be increased immediately.

(2) *Financing of Federal programs.*—To make the needed expansion of Federal assistance possible, a new method of financing those programs which involve no subsidy—the insurance and loan programs—should be devised to remove their dependence on appropriated funds, or methods of budget presentation should be revised so that these transactions, which involve no ultimate expenditure, are not classified as outright expenditures.

(3) *Community organization and leadership.*—In order that all of a community's resources may be mobilized to deal with the housing problems of its elderly citizens, the restriction which forbids local housing authorities to participate in the direct loan program should be modified.

(4) *Research.*—The Housing and Home Finance Agency should undertake a major research program to obtain far better data than now exists on the housing needs of the elderly and the desirability to older persons of various housing arrangements.

(5) *Community planning.*—Federal assistance to community planning should be expanded to provide aid for surveys of the housing needs of the elderly in each locality and the development of comprehensive community plans.

(6) *Urban renewal.*—In order to ease the impact of urban redevelopment on housing for the elderly, steps should be considered to—

(*a*) Encourage local public agencies to make sites available in urban renewal project areas for development by cooperative and other nonprofit sponsors of housing for the elderly.

(*b*) Authorize the Federal Housing Administration to insure mortgages for the rehabilitation of the residence of an elderly homeowner on terms which do not require full amortization of the loan.

(*c*) Authorize rent subsidies for limited periods to enable persons displaced by urban renewal or other Federal programs to obtain decent housing, the subsidies to be included as part of the project cost.

RESEARCH NEEDS IN HOUSING FOR THE ELDERLY

Some of the recommendations made by the Subcommittee on Housing for the Elderly echo recommendations put forward by the Subcommittee on Problems of the Aged and Aging in its 1960 report. One of the major needs pointed out by the special committee's predecessor in which very little progress has been made is in the area of research.[5]

Although the Housing Act of 1956 carried a general authorization for housing research there has been no congressional mandate for research specifically in housing needs and problems of the elderly. No funds were appropriated for research under the 1956 authorization until fiscal year 1962. In that year and again in fiscal year 1963, only $375,000 were appropriated for all housing research.

On the motion of the chairman of the Special Committee on Aging, the sum of $125,000 was restored to the 1962 appropriations for the Housing and Home Finance Agency to permit special tabulations of 1960 census data on the housing conditions of our older citizens. These tabulations are now complete and represent a valuable source of information. However, this is the only significant item of research accomplished since the 1960 report of the subcommittee forcefully called attention to the need. A research program commensurate with the magnitude and complexity of the problem remains a major piece of unfinished business.

THE SUBCOMMITTEE ON INVOLUNTARY RELOCATION OF THE ELDERLY

The Subcommittee on Problems of the Aged and Aging in its 1960 report recommended—

> * * * priority attention * * * toward (1) the provision in redeveloped areas of housing of moderate cost suited to the needs of older people, and (2) special consideration and assistance in the relocation of older people displaced by urban renewal programs.

Little real progress has been made toward meeting the needs underlying this recommendation. The Subcommittee on Housing for the Elderly in its 1961 hearings again found that housing suitable for the elderly is too infrequently a part of the reuse plans of urban renewal project areas and received a considerable amount of testimony on the difficulties encountered by elderly people when displaced from their homes by public programs. Recommendations were made by the subcommittee on both of these points.

The growing magnitude of the displacement problem and its special impact on the living arrangements of elderly residents of urban areas led to the formation, in October 1962, of the Subcommittee on Involuntary Relocation of the Elderly.

This subcommittee is now active in studying the extent and the problems of displacement from all types of public programs and attempting to assess their future implications for our goal of providing a suitable living environment for all senior citizens.

The subcommittee has conducted six public hearings thus far and its preliminary findings indicate that—

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[5] See also ch. IV, "Research—A Key Factor."

(1) There is a serious lack of reliable information on total displacements from projected public works and redevelopment projects and, consequently, an inability to plan effectively for appropriate rehousing of elderly people affected.

(2) The lack of relocation provisions in programs other than urban renewal, such as construction of highways and public buildings, works a serious hardship especially, and most often, upon the elderly persons affected, and that even in the urban renewal program, the elderly represent the most difficult group to satisfactorily relocate.

(3) In many cities, and possibly in the Nation as a whole, the production of housing suitable for elderly people and within the rent ranges which most can afford is not keeping pace with the rate at which existing units at these rent levels are being torn down as a result of changes in urban land use.

It is apparent that these problems must be more precisely defined and solutions found to avoid losing ground in our efforts to improve the housing of America's older people as well as to prevent delay or abandonment of many worthwhile urban improvements.

EFFECT OF CAPITAL GAINS TAX ON SALES OF HOMES OF OLDER PEOPLE

A great many elderly retired couples and widowed individuals live in homes much too large for their needs; to their physical and financial detriment. Typically, these are people who are remaining in homes in which they have reared their families and to whom the homes, although no longer suitable, represent a base of security.

This security, however, often is illusory. Housekeeping in the large home may become more of a physical burden than the elderly occupant can manage, and dietary and living standards may suffer as a result. The maintenance of an old house may be beyond their physical and financial resources and the property may begin to deteriorate. Finally when the situation becomes untenable, a move is forced at a time of life when the move is most difficult and the chances of adjustment to new surroundings least favorable.

The point has been made in hearings before the committee that the tax on the gain realized from the sale of the family home acts as a deterrent to the older person or couple in providing more appropriate housing for their retirement years. Moreover, when the sale is made, the tax reduces the proceeds available to them for their future living expenses.

It is generally recognized that accumulation of equity in a home is the predominant method of saving for middle and lower middle income American families. It is common for such families who are homeowners to reach retirement age with the homestead as their major, if not their only substantial asset. The capital gains tax applies to the liquidation of this asset which represents the basic financial resource of the retirement years. Thus, in many situations, the capital gains tax taxes money saved for retirement, and is to that extent a contradiction of the value set on individuals providing for themselves through the assets they acquire during their working lives.

An amendment to the Internal Revenue Code exempting from taxation all or part of the gain on the sale of a residence by a taxpayer age 65 or over was adopted by the Senate in the 2d session of the 87th Congress. House and Senate conferees did not retain the provision in the conference report. However, similar legislation is likely to be introduced in the 88th Congress.

Although the amendment adopted by the Senate last year would have benefited the elderly homeowner in the situation described above, several changes (among them those suggested by the chairman of the Special Committee on Aging during debate on the amendment) should be made.

(1) Eligibility for the tax exemption at age 65 can have the effect of encouraging many to hold their homes beyond the time when a change would be most appropriate for them. Most authorities contend that the family homestead should be exchanged for smaller and more efficient quarters before actual retirement. Before retirement the physical and financial burdens of a move are less severe. The orientation of daily life is still to employment, and the emotional dependence on familiar surroundings is subordinate.

In order to give sufficient flexibility to achieve the purposes of the amendment, age 55 is suggested as the optimum minimum age.

(2) Safeguards are needed to prevent repeated use of the exemption. Legislation should limit in specific terms the right to exclude gain on residence from gross income to one transaction.

(3) The formula for determining the amount of gain exempted contained in last year's amendment would reduce the tendency of the provision to favor upper income groups, but still could allow some very substantial windfalls for wealthy taxpayers. Since the purpose of the amendment is to protect the financial resources saved for retirement by those in economic groups for which homeownership is the major saving medium, an upper limit of $10,000 is suggested on the amount of gain which may be excluded from gross income.

With these modifications such an amendment to the Internal Revenue Code would be in the national interest and would be in keeping with a national policy of promoting self-sufficiency and independence of senior citizens.

B. Institutional Homes for the Aged [6]

The great changes in homes for the aged

Historically homes for the aged have represented one of the earliest expressions of community concern for the welfare of older people bereft of family, friends, and funds. It is this ancient and wonderfully persistent concern that underlies the widespread development in recent decades of programs designed to meet the varied needs of a vastly increased older age population. In recent years, however, particularly in the 1940's and the 1950's, very significant changes in these programs became apparent.

[6] The committee would like to acknowledge its great indebtedness to the American Association of Homes for the Aging and, in particular, to its executive director, Mr. Lester Davis, for guidance and assistance in the preparation of this section of the report.

Traditionally, homes for the aged provided food, shelter, and varying degrees of amenities for old people who, while poor and without family, were for the most part in fair physical and mental health, ambulatory, and able to care for their own physical needs. Today a great transition is occurring. Homes that were established decades ago to care for relatively well elderly people found that their residents, instead of dying off at a relatively young old age with the help of "pneumonia, the old man's friend" and other now controllable ills, were living on into ages that almost inevitably were accompanied by chronic illness resulting in bedfastness, physical dependency, and the need for nursing care. Newer homes and those now contemplated by voluntary, nonprofit organizations are designed to serve not the hale 65-year-old, but the frail, the infirm, and chronically ill persons 75 and up who need a home away from home. Also underlying this change is the development in advanced communities of a network of services available to the elderly which permits the older person a choice of living arrangements.

The social security program is by far the most important factor underlying this change. The financial ability to maintain an independent residence plus the evident wish of older people to remain in their own homes have altered subtly but inevitably and irrevocably the purpose of homes for the aged.

Now, along with the development of "homes" that are, in reality, "nursing homes," we are witnessing the concurrent and coordinated development of so-called shelter-care facilities. Those nonprofit organizations planning imaginative programs for the elderly in the 1960's think not just of the construction of a "home" but of the development of a network of services and of facilities, some owned by the group, some not, but all related by the identification of the elderly people living in them to a common program.

Typically such a program revolves around a center (often called a senior citizens center) which provides the older person with an opportunity for recreational and purposeful activity and that identification with a group of his peers who regard him as an individual with dignity that keeps his life meaningful. The individual participating in such a program may live in his own home or apartment in the neighborhood, he may live in a noninstitutionalized foster home, recruited and approved by the organization, or he may live in a housing project owned and operated by the organization. In any case, he is part of a group which not only provides him with opportunity to live as independent and satisfactory a life as is possible, but which give him that all important sense of security against what is perhaps the greatest fear of the elderly—the fear of being unattended and homeless in case of illness. For, in addition to the center for recreation and activity, today's well-rounded program for the elderly will provide both medical care and hospitalization to assure his prompt return to independent living whenever possible and, in its "home," an assurance both of continued care and continued identification with his group for as long as it may be needed when independent living is no longer possible.

In addition to those we've mentioned, there are other major factors responsible for the development of shelter-care facilities:

The steady rise in the number of those 65 and over and the even more rapid increase in the number 75 and over.—The U.S. Bureau of the Census projects an increase for the country as a whole for those 65 years and older from 15.8 million in 1960 to 19.5 million in 1970 to 24.5 million in 1980 to 35.2 million in the year 2000; for those 75 years and older from 5.5 million in 1960 to 7.3 million in 1970 to 9.2 million in 1980 to 16.5 million in 2000. Forty years from now the population 65 years and older will have doubled but the population 75 years and older will have tripled.

The increase with advancing age in the incidence of physical or emotional frailty or illness.—The 1957–58 U.S. national health survey reveals that 75.6 percent of the population 65–74 years old had one or more chronic conditions; that 27.8 percent were partially limited as to activity and 9.4 percent were unable to carry on major activities. The same source shows that 83.1 percent of the 75-plus population had one or more chronic conditions and that, respectively, 31.1 percent and 23.7 percent were partially or almost fully limited in respect to major activities.

Financial limitations stemming from small incomes and inflation.—*Shortages of suitable low-rent housing and standby community services* such as housekeeping, shopping and meal services that permit comfortable and safe independent living.

The desire of many older persons of the same religious faith or with some other common interest to live together.—This is particularly true for the lone or last survivor in a family or in situations where families are widely scattered.

The foregoing factors combine to account for the increase in the number and in the capacity of institutions for the older person who, because of infirmity or illness or the paucity of other services, needs care outside his own home but does not need hospital or definitive medical care.

The traditional American pattern for initiating welfare and health services is under nonprofit auspices, either public or voluntary, with payments for care geared to the recipient's financial ability. In large measure response to the need for institutional care has come through these customary channels. One larger denomination reports that homes for the aged under its auspices increased from 35 to 72 in the period 1950–60. Fraternal organizations have long provided such services and are actually increasing them. Nonsectarian homes are being added. Nonprofit cooperatives which are quasi-homes for the aged are multiplying in parts of the country, spurred by Federal assistance in the form of insured loans. Cities and counties are renovating old facilities and constructing new ones. Labor unions have begun to provide such service. The variety of needs that come with the changing physical and mental conditions of elderly individuals has led to the provision of multiservice facilities with a range of service from simple domiciliary to skilled nursing care.

New to the scene is the tremendous and growing complex of proprietary facilities.—This is a unique phenomenon on the welfare and health scene, with its own gamut of problems arising from mushroom growth, from motivational differences in origin, from the profit objec-

tive which when equated to high costs may be fine for the few but when equated with low standards can be terrible for the many. What is perhaps most disturbing about this development is the absence of community accountability that responsible lay boards of directors (concerned about deficits rather than profits) provide. New to the scene also is the American Nursing Home Association whose dues-paying members are concerned that standard setting shall not price them out of the market and that legislation favorable to their interests shall be enacted. On the national level and in many States it was the Nursing Home Association, well-financed and centrally located, that until the formation of the American Association of Homes for the Aging presented itself as the spokesman for the old person who is frail and ill, rich and poor alike.

Figures as to the number and capacity of institutions serving older people are, at best, estimates to be cited with caution in the absence of reliable counts and precise definitions. One source of data is a report titled "Nursing Homes, Their Patients and Their Care" issued in 1957 by the Public Health Service of the U.S. Department of Health, Education, and Welfare. Nursing homes and related facilities are estimated at 25,000 with an overall capacity of 450,000. Of this number nonprofit homes number some 4,300; 2,600 voluntary and 1,700 public. Bed capacity in the nonprofit homes is estimated at 217,900; 120,100 voluntary and 97,800 public.

Care of the aging is a complex matter. Much more than the provision of room, board, and clothing is involved. Modern homes offer a wide range of services including medical and nursing care, rehabilitation, recreation, creative and educational programs, opportunities for worship, and participation in outside community activities.

The obvious health problems incident to the aging process have led to attempts to focus attention on this phase of aging to the exclusion of others. To many legislators and Government officials, a home for the aged is equated with a nursing home, a geriatric hospital, or a custodial facility for the forgetful.

To many administrators and board members of nonprofit facilities, this oversimplification and understatement of the needs of older people is variously disturbing, confusing, or overwhelming.

This was the background and situation which resulted in a most significant recent development, the establishment of a national group representing nonprofit homes.

An association of nonprofit homes for the aged

Growing concern about all aspects of congregate care became apparent from the mounting volume of inquiries in the 1950's. These have been directed to the National Council on the Aging and to denominational, regional, State, and local associations of homes for the aged, many of whom came into being in response to this pressure. This search for solutions to perplexing problems accounts for the scheduling of numerous conferences and workshops under the auspices of national and local organizations, geriatric societies, universities, and others.

Out of this fragmented ferment came awareness of the need for some type of central organization to afford a means for intergroup communication and to represent the interests of all nonprofit homes for the aged. A small but representative group met in January 1960

to discuss the need and, ultimately, to seek the good offices of the National Council on the Aging to facilitate a meeting on the occasion of its 10th anniversary celebration.

Nonprofit homes for the aged are provided for under a variety of auspices; religious, nonsectarian, and governmental. In spite of the fact that their aims and purposes are quite similar, there was no mechanism for communication among them. The Jewish homes had an association and some of the major Protestant denominations had established national offices for service to their own groups, but even among these there was practically no exchange of experience and ideas. For this reason, the convening of the conference in October was a most significant milestone. Values gained from personal exchange of common problems gave evidence enough of the desire for continuing means of intercommunication.

Not satisfied that the convening of an exploratory conference of voluntary and governmental homes for the aged would definitely establish the desire for a national organization, the original group decided to test the reality of the need by surveying, via a mail questionnaire, a representative sample of homes under public, nonsectarian, national, fraternal, union, and various denominational auspices.

It is significant to note that an overwhelming majority saw a clear need for the development of a national medium for nonprofit homes to share experiences, to express their point of view, and to influence matters affecting daily operations.

The exploratory conference was held October 20–21, 1960, in New York City, and to it came 210 men and women representing homes and agencies from Maine to California and from Minnesota to Texas. Not all were administrators; some 40 served as board members. Medicine, social work, and the related disciplines were represented. State officials and staff from the Federal Government participated.

It was a working conference with the delegates divided into four workshops addressing themselves to three questions:

(1) What were the problems confronting homes?
(2) What methods would solve them?
(3) How could these be developed?

The workshops were generally agreed that their problems were the same no matter what their auspices or in what part of the country they were situated; accommodation to change, personnel, financing, relations with government and community.

They felt that paramount in helping them meet these problems was an association with three major functions:

(1) A central source of information, counsel, and assistance.
(2) Assistance in developing leadership to evaluate the functions and responsibilities of nonprofit homes in a changing era.
(3) Serving as a common voice.

Care of the aging involves virtually all the helping professions and many learned disciplines. An association would be valuable in providing a continuing relationship with such bodies as the American Medical Association, the National Association of Social Workers, the American Public Welfare Association, and the American Public Health Association, to name only a few outside the Federal Government itself. Because of its special interest, the American Hospital Association would be intimately involved in the new association.

The conference felt the need for the compilation of a directory of nonprofit homes for the aged; saw the need for regional conferences from time to time; suggested that consideration be given in due time to communication and cooperation with the proprietary nursing homes.

With amazing unanimity the four workshops recommended that the new association, whatever its form, be related to the National Council on the Aging.

It seemed obvious to the participants that the historical isolatedness of homes for the aged from the stream of community planning should not be perpetuated with a totally independent association. Moreover, it was believed that the association could enhance as well as benefit from this tie-in.

Also, the National Council on the Aging has long been concerned about institutional services for the aged—the quality and gamut of care provided, the appropriate use of scarce and increasingly costly space and staff, the relation to all other community services. This is evidenced by: (1) Publication in 1953 and 1954 of a three-section guide on "Standards of Care for Older People in Institutions;" (2) release in 1955 of a documentary film titled "A Place to Live" supplemented by a bibliography and discussion outline; and (3) issuance in 1959 of a book, "Planning Homes for the Aged," a planning guide on design and construction which grew out of a cooperatively sponsored architectural competition. The compilation and distribution of these special and widely used "tools" was financed through the National Council by special, extra-budgetary grants.

Consequently, the American Association of Homes for the Aging came into being under a grant to the National Council on the Aging from the Ford Foundation. The grant was to assist the association during its formative years.

The committee is pleased to note that since the establishment of the association in 1961 it has moved steadily ahead on programs conceived during its formation. A directory of homes has been published for the first time in 20 years. The association, representing nonprofit homes, has been approached by the Joint Committee on Accreditation of Hospitals to participate in a program of accreditation to be conducted on the division of inpatient care institutions other than hospitals. Two periodicals have been inaugurated to provide a year-round informational exchange between member homes. The association's first annual meeting was held in October of 1962 and was attended by more than 300 homes from 25 States and included representatives of a number of significant government agencies.

The sudden increase of informational exchange brought about through the formation and establishment of an Association of Nonprofit Homes has brought many elements affecting their present and future status into much sharper focus.

The nonprofit home for the aged, either governmental or voluntary, was once considered the basic social resource for the aged when individual and family resources failed. It can no longer be doubted that this home for the aged as conceived of and developed in previous decades is no longer the sole or perhaps even basic social resource for meeting the rapidly growing numbers of elderly in our communities.

Present factors of change are constant

Among the many pressures to which nonprofit institutions, and especially homes for the aged, have been subject in recent years are:

(1) The very great increase in the absolute and proportionate numbers of older persons in our society—the increase of the aged from 4 percent of the population to 9 percent in the last 50 years (and the increase to 12 percent and even 15 percent in some parts of the country); and a rate of increase during the past 50 years which has averaged four times that of the total population. The facts are pretty well known; the conclusion has not been so readily accepted. Once our society began to consist of a very large number of aged persons, numbering today over 17 million, it became impossible for society to rely upon institutional care as the primary method for meeting this population's need. Isolation in institutional walls became unacceptable both to the aged and to the society at large when the numbers concerned and affected rose to the many millions.

(2) The extension of social security in many forms is the second major development. Despite automation and the well-recognized economic insecurity of the elderly, our social provisions for meeting their economic needs have advanced very far in the past 25 years. Social security, old-age assistance, industrial-union health and welfare programs, industrial retirement plans, and the savings of many in an affluent society, taken together, constitute a vast extension of social security provisions unthinkable only a few decades ago. We now confront a situation where the elderly, by and large, have some economic choice as to where and how they will live. The means are not yet generous and the elderly must shop with care, but the reality of economic choice can now no longer be denied. All observed experience and all systematic studies indicate that most of the elderly can choose some independent form of living near their families. This means a private residence of some type which can respect the limiting facts of age. This preference on the part of the elderly is not only confirmed by studies but also by the changing character of applications to most homes for the aged. The preference represents not only a search for privacy but a yearning to retain the familiar. Recent studies in Boston, for example, indicate how many elderly persons, displaced in an urban renewal program, move within a few blocks of their previous residence (even at the price of moving into deteriorated private accommodations) rather than moving any distance from their familiar surroundings.

(3) Changes in mortality and morbidity constitute the third significant development. The conquest of acute illness has brought with it the dilemma of long-term or chronic illness which is now a major health problem. Persons who survive to 65 years may anticipate between 16 and 17 years of life in retirement; a third of those over 65 are over 75. The problems of physical, nursing, and medical care for those who become seriously disabled is increasing. The more older persons live, the greater is the demand for adequate attention to these serious disabilities. The fact is that most nonprofit institutions have only recently faced this issue for themselves. It is no longer satisfactory to say "a home will

take the well aged." If residents are kept when they become ill, homes must determine the range and extent of care they are prepared to offer and the changes this will make in staffing, facilities, and programing.

(4) Another significant factor for change emerges from the preceding—the growth of proprietary or commercial nursing homes, especially since 1940. Aided by social security benefits and the economic means of the elderly to purchase care, proprietary homes have grown at a phenomenal rate and much more rapidly than the nonprofit or governmental institutions for the chronically ill or aged. It is significant that so many aged have either chosen voluntarily, or been forced to enter for lack of other resources, proprietary nursing homes. Sometimes this resulted from the simple absence of nonprofit institutions; or often it has developed because nonprofit institutions have been slow to accept the types of patients proprietary nursing homes are willing to accept.

These major circumstances confront homes for the aged—their administrators and policy makers—and community health and welfare planners with certain critical choices.

Alternative directions for the future

Although comprehensive data are lacking on the scope and variety of services being provided by homes for the aged, certain patterns of direction are developing in this field.

Homes may serve the well aged—meaning those with minimum physical, nursing, or medical needs and capable of caring for themselves. This direction means one of two things:

(1) Homes may choose to retain for themselves a residual function of caring for the socially inadequate, meaning those older persons who never in their adult lives really got along in society, have always been inept and more or less marginally helpless and simply become increasingly helpless in their older years. There are always a certain proportion of such socially helpless individuals although as the techniques of home care improve, the numbers requiring an institutional solution will undoubtedly decline.

(2) If the residual task is not to be the only horizon, then homes which seek to serve the well aged must attempt to meet the hunger for decent housing at low cost. This inevitably means competition with other forms of housing, but competition in a field with more than enough room for all for decades to come. Governmental low cost housing, cooperatives, housing constructed by union welfare funds, and even housing by private builders are all beginning to serve this irresistible demand. Nonprofit homes for the aged may attempt to also provide competitive forms of housing for older persons but a number of questions inevitably arise. Will the tax-exempt status of institutions be affected if they provide such housing only for those capable of meeting the full cost? Is there truly room to experiment especially with imaginative ways to bring community health and welfare programs to serve the aged in private residences—nursing care, medical care, physical rehabilitation, occupational therapy, leisure time services, opportunities for creative living, etc.

A number of homes have experimented imaginatively with this option. A few have constructed experimental apartment houses or apartment house units as adjuncts to their homes. Some other nonprofit organizations have built residences which are frankly not experimental but appeal especially to the housing aspirations of professional and middle-class persons capable of paying the full cost. These very attractive forms of institutionally sponsored housing have appeared especially in the vacation areas of the west coast and the South.

It has been many years since private philanthropy in America experimented in housing. Not since the early days of the Charity Organizations Society, the Association for Improving the Condition of the Poor, and the Russell Sage Foundation have philanthropic organizations attempted to finance experimental housing operations comparable to Sunnyside in New York or residence programs for the aged in Manhattan.

A second option is for the homes to concentrate on care of the physically and mentally ill who require long-term nursing and attendant care under humane conditions which come as close to home life as an institution ever can. This option, of course, requires that homes for the aged become more and more related to our medical care system without, however, abandoning the obligation to provide for the social conditions which surround medical care. The need for more and better facilities for the physically and mentally ill is a gross need. Studies universally reveal the extent to which general hospitals retain chronically ill and elderly patients long beyond a necessary period or discharge them to very poor home environments because there is no proper place to receive them once hospitalization is completed. Nearly all national, regional, and local studies of the subject have highlighted the urgent need for prehospital and posthospital facilities for the care of the long-term patient—facilities which will be adequately related to the system of health and welfare so that comprehensiveness and continuity of social and medical care can be assured.

If homes are to adopt this option effectively and to apply the technical knowledge which has already been tested, they face a major shift in their concept and their organization. A number of homes have embarked upon this course; some have converted completely into institutions for the sick; others have partly converted their facilities through a great strengthening of their infirmary programs.

Development of this option requires the development of separate facilities and programs for the sick and separate planning of their care from the programing for the well aged. This is based upon the thesis that the needs of the sick are not identical with those of the well aged and that modified facilities and techniques are required. To illustrate, such programs require paid continuous medical supervision and an abandonment of the traditional reliance upon the voluntary supervising physician of good will. The medical director in such homes needs to have firmly in his hands responsibility for the health of patients under the general administration of the home. Arrangements must be

made for ready access to special consultants as needed. Not only are regular medical examinations required but sensitive probing and comprehensive examinations are necessary. Arrangements must be made for ready transfer to hospital when more difficult treatment is required and for rapid return of patients from hospital when treatment is completed.

The flow between home and hospital needs to be predicated not upon arbitrary eligibility processes but upon patient needs. The goal of such homes becomes a steadily greater capacity to accept and care for sicker and sicker patients. For example, in one large midwestern community, it was found that certain serious cardiac patients, once traditionally transferred to the hospital, could be satisfactorily cared for by the home for the aged once it undertook to develop its medical and nursing program. There are undoubtedly many medical conditions which have forced older patients into hospitals because the institutions caring for them lacked the personnel or the self-confidence to provide secure care itself.

However, medical direction is not the only key to such an institution. Nursing complements need to be increased, especially the ratio of registered nurses. Increases in rehabilitation, especially for self-care, are indicated and such rehabilitation may later aspire to discharge residents as much as to improve their capacity for institutional self-care.[7]

Perhaps most important is the fact that this type of program is required by mature adults under 60. The logical conclusion is that such a nursing institution can readily admit patients flexibly according to their need and the institution's technical capacity to handle the condition rather than by arbitrary age limitations. This does not imply that persons of all ages will necessarily be accommodated but certainly mature adults can be.

This course of action cannot be undertaken without attention to the needs of the mentally ill. Most homes have mentally disoriented residents in varying proportions. A recent national study of Jewish homes for the aged indicated that mental illness or aberration is the single most frequent medical condition found in residents of such homes.

The third option is for homes for the aged to become multipurpose centers for the aged. Such multipurpose centers can include both of the previous options but they can truly achieve their potential as centers if they add responsibility for many other services to the elderly outside of an institution. A center under a single administration can assemble staff, skill, and facilities to provide social home care (not medical home care), rehabilitation to nonresidents, personal counseling, supervised foster care, recreational and purposeful activities, etc., to a wide range of elderly persons as well as to their own residents.

This option would keep the home for the aged focused sharply on the needs of the elderly alone, a focus justified by the variety and multiplicity of services extended to the elderly, and in this

[7] For a further discussion of the role of rehabilitation, see below, p. 124.

respect differs from the home which chooses to serve the physically and mentally ill primarily.

Some homes for the aged have tentatively experimented with such a course. Some of them have changed their names to reflect this aim. A few homes here and there provide both extensive nursing and medical care for the chronically ill, nonhospital patient, and also residential care in apartment house units. A few offer various types of boarding-out programs. A number offer recreation, sheltered workshops, and rehabilitation to nonresidents. These varieties of noninstitutional services by a home or a center are admittedly a minor part of nonprofit homes for the aged to date but they do suggest interesting lines of experimentation.

The problems ahead

The problems which confront homes for the aged as they consider these choices are many indeed, but so are the opportunities. In one sense homes face a very serious crisis: Competitors from many directions, changes in the character of applications, a rise in costs, confusion about institutional roles, backward looking boards and staffs who hope to recapture the past, skeptical and doubtful health and welfare planners, and reluctant contributors.

There is widespread confusion about what a "home" is today and should be tomorrow. There is anxiety about accreditation and licensing and the extent of future governmental control. Finally, there is the competition of proprietary enterprises and their march toward organizational influence.

None of these problems is insurmountable. Boards do learn. Commercial nursing homes fail as often as their owners grow rich.

More important than all of these doubts and difficulties is the realization this committee has found among those dedicated to the care of the elderly that each crisis is an opportunity. The elderly present very great unmet needs for housing at low cost, for nursing and attendant care, for decent care for the mentally ill, for home care, for rehabilitation, for opportunities for constructive living. Concern about meeting these needs is widespread in most of our communities or is becoming widespread. The needs certainly exceed present facilities and present techniques.

The committee believes that the American Association of Homes for the Aging has provided a significant medium through which these major issues can be evaluated, solutions tested, and programs supported. It strongly recommends that all governmental agencies operating in fields related to the work of the association lend it their utmost cooperation.

C. Nursing Homes

The proprietary nursing home is no longer a disreputable stranger. It is a major factor in our medical and welfare system. The number of nursing home beds in the United States now equals, if it does not exceed, the number of acute hospital beds, and a very large proportion of these nursing home beds are under proprietary auspices. The proprietary homes in most parts of the country are already organized or at least significant minorities of them have banded together for self-

organization. Many of these associations of nursing homes have begun to develop the rudiments of professional responsibility. In New England, one such association has sponsored systematic studies of characteristics in proprietary nursing homes with the assistance of Federal research funds. It sponsors classes for its administrators and personnel, and aspires to develop minimum standards.

Rehabilitation services in the nursing home

In 1960, the Subcommittee on Problems of the Aged and Aging, predecessor of this committee, published a study "The Condition of American Nursing Homes." [8] This study, together with the published reports of the public hearings on nursing homes held by subcommittees of the Special Committee on Aging in Hartford, Conn., Boston, Mass., Minneapolis, Minn., Portland, Oreg., Walla Walla, Wash., and Springfield, Mo., encompass and present the committee's findings with respect to nursing homes in the United States.[9]

The study and the reports are available and consequently we shall not attempt to review the nursing home picture. In the course of these hearings, however, it became apparent that more attention must be paid to the role which rehabilitation should be playing and all too often is not playing in the nursing home of today.

Rehabilitation is increasingly being recognized as one of the major services that should be provided in nursing homes. To bring persons disabled from illness and disease to the point of reaching the maximum degree of independence is the goal of rehabilitation. Sometimes what is involved is preventing "disuse phenomena," through which persons suffering from an acute condition degenerate physically as a result of not using their muscles, developing bedsores from prolonged pressure, or having bone atrophy set in as from a lack of proper weight bearing. Other types of disability result from the original illness in which case speech therapy, respiratory aids, and physical therapy methods of various types may be required to overcome the handicap.

The process of providing rehabilitation is not, then, a simple one. Experts in the various fields of therapy must be utilized. In addition, the psychological problems which beset the aged who have suffered serious illness produce obstacles that must be overcome in achieving maximum rehabilitation. Experts on rehabilitation techniques point to the need to begin restorative services at the earliest possible time, and this frequently means within a few days of the onset of the illness.

For the aged person suffering from an acute condition for which hospital care is provided and who is later moved to a nursing home when the acute condition is no longer present, it is essential that rehabilitation services, hopefully provided by the hospital, be continued in the nursing home. What is involved in providing these services was the subject of several witnesses before the nursing home subcommittee field hearings. Dr. Frank H. Krusen, director of the Sister Kenney Institute in Minneapolis, Minn., outlined what is

[8] Committee print, 86th Cong., 2d sess., printed for the use of the Committee on Labor and Public Welfare, U.S. Senate, Government Printing Office, Washington, 1960.
[9] For copies, address Special Committee on Aging, room 132, Senate Office Building, Washington, D.C.

involved in rehabilitation. Here are some excerpts from his statement:

> One of the most important things, we think, in nursing homes is to provide training of nurses in rehabilitation nursing services and we feel this is extremely important. * * * I have felt particularly the need for a disability detection program and the need to do everything we can to lessen the number of beds in nursing homes by providing adequate rehabilitation services. * * * Initially rehabilitation is three to four times as costly as routine care, but in the long run it is considerably less expensive. Rehabilitation may take many months, but passive institutional care can go on and on indefinitely in nursing homes and in addition rehabilitation offers benefits which cannot be measured in terms of dollars; among them, hope, a chance of obtaining some degree of independence, and the prospect of returning to one's own home rather than remaining in a nursing home.

Continuing, Dr. Krusen commented: "We have progressed a long way from the attitude of regarding the nursing home as a mere way station on the way to the grave." Unfortunately, very few nursing homes are equipped either with facilities or staff to provide rehabilitation services. Thus, while medical knowledge can make rehabilitation a reality, the institutional means of putting that knowledge to work have been made available to but a very few nursing home patients.

There are an increasing number of doctors, nurses, nursing home operators, and specialists of various types who are concerned with bringing rehabilitation services to the nursing homes. Government agencies, too, are becoming increasingly aware of the rehabilitation potential of nursing home patients. Outstanding work in the field has already begun through the Office of Vocational Rehabilitation. The Office of Vocational Rehabilitation sponsored special studies in several parts of the country, studies that are showing, for example, that—

> After several months' participating in the total rehabilitation program all 37 patients in the demonstration group * * * achieved the predicted potential of functional efficiency and independence.
>
> Seventy-five percent achieved a status which enable them to be considered for placement outside the hospital. Of this group 12 were placed by the time of the report and others have been discharged since. The advanced age of most made employment in competitive industry unrealistic, but at least one-fourth were able to care for their independent living quarters and to do some work in sheltered situations, (Office of Vocational Rehabilitation Publication 154–61).

The Office of Vocational Rehabilitation work is being done in both urban centers, Chicago, for example, and in rural areas. A West Virginia study which is concerned also with rehabilitation from the standpoint of a depressed area demonstrates again how the problems

of the aged cannot be isolated from one another and from the problems of other segments of society.

In Washington State outstanding work is being done in the vocational rehabilitation field, as Dr. Ross C. Hamilton testified in Spokane. Dr. Hamilton is the director of the extended services program, vocational rehabilitation, department of public instruction. Beginning his testimony with an explanation that the vocational rehabilitation program is operated by a partnership of the Federal and State Governments, Dr. Hamilton stated:

> The skills and knowledge of the rehabilitation process are now being used in two ways: (1) To improve the self-care rehabilitation of persons; and (2) to adapt the environment of persons to things in order to define the dependency of the person.

The consequence is that premature dependency can be avoided and dependency can be kept at a minimum. The Washington program demonstrates

> * * * some aged and aging citizens are now receiving the benefits of the Federal-State vocational rehabilitation program for the disabled, and also there are some receiving the benefits of the State of Washington program for the nondisabled public assistance recipient. * * * Fifteen of the workshops in the State are now extending work opportunities to aged persons 60 years of age or more. In these programs, senior citizens are able to augment retirement benefits, personal savings, and other limited income. The result is that dependency is reduced, usefulness achieved, and happiness produced. Other older citizens, through the rehabilitation services, have been assisted into new jobs compatible with their abilities to produce.

Changes in the Washington State law were made in 1957 "to render rehabilitation services to persons lacking social competence or mobility, to enable them to obtain or maintain the maximum degree of self-support and/or self-care." Dr. Hamilton emphasized that Washington's program embraces "premises not yet incorporated on the part of the Federal laws relating to vocation rehabilitation." He suggested that Congress "may wish also to reexamine the several independent living bills under consideration in the last few sessions."

The purpose of the bills to which Dr. Hamilton had reference have the following objective, to quote from one of them:

> To provide evaluation of rehabilitation potentials and rehabilitation services to handicapped individuals who as a result thereof can achieve such ability of independent living as to dispense with the need for expensive institutional care or who can dispense with or largely dispense with the need of an attendant at home; to assist in the establishment of public and private nonprofit workshops and rehabilitation facilities; and for other purposes (S. 772, introduced January 29, 1959).

In considering the rehabilitation potential of older persons, the Office of Vocational Rehabilitation is increasingly concerned, then, with rehabilitation to achieve a maximum degree of self-care. This concept is quite different from the previous emphasis on rehabilitation to achieve the status of employability for the disabled.

Several specific studies of the rehabilitation potential of the aged in nursing homes have been completed, and others are in process. The knowledge gained in this field is bright with the promise that nursing home patients, in fact, do have a future.

From the foregoing remarks on rehabilitation in nursing homes there emerges a conclusion which must be pointed to regarding the relationship of all medical facilities and services connected with nursing homes. That conclusion is that no aspect of the medical care required for the nursing home patient can be isolated and carried on as a separate function from the other medical needs of the patient. Rehabilitation, we have seen, usually must begin in the hospital, continue in the nursing home, and requires followup if the patient leaves the nursing home for a less sheltered environment or again becomes an independent member of society.

Integration of community health and social services

Equally important is that the proper medical facility be available to nursing home patients, whether it be a general hospital, a mental hospital, an outpatient clinic, a chronic disease hospital, or an infirmary in a home for the aged. An integration of services is a requisite if the nursing home patient is to be afforded a full range of medical services. As we point out elsewhere in this report, dental needs of nursing home patients, for example, must be met, and often in the nursing home even though those needs do not have a direct bearing on the chronic condition which brought the patient to the nursing home.

The integration of services for the nursing home patient, however, involves more than medical services. The need for a sense of participating in useful activities, recreation and social considerations, religious needs, and economic problems, all have an impact on the nursing home patient. The services connected with filling these needs can sometimes come from within the nursing home, but often must come from outside. Counseling and religious guidance are usually provided, when available, by persons who are not a part of the regular nursing home staff.

From the nursing home experts who testified on what are the needs of nursing homes, two important factors were brought out: (1) A much greater integration of medical and other services must be accomplished inside of nursing homes, and (2) medical facilities and social services on the community level must be integrated to provide the aged with a full range of health services. The emphasis on out-of-hospital care provided in the Community Health Facilities Act of 1961 will provide significant assistance, as several witnesses testified, in achieving a greater integration of health services.

A part of the problem, however, is one of attitude, as may be noticed in the discussions below. Nursing home operators, hospital administrators, superintendents of mental hospitals, and others who are directly concerned with caring for the aged need to be brought

to a better understanding of how they can help each other. Another part of the problem is an educational one among social service groups, both at the professional level and among volunteers, as to the role they can play in administering to the wide needs of the nursing home patient.

The rationale for integrating services for the nursing home patient was stated at the Portland hearing on nursing homes by the director of the Institute of Gerontology at Mount Angel College, Oregon, Miss Geraldine Pearson:

> When the word "home" comes into the picture, it enlarges the focus to a place where the complete man is cared for. What are his needs beside nursing care? Should his spiritual life, his need of love, his need of rehabilitation, financial security, or his recreation be the concern of the nursing home? Is it the responsibility of the nursing home to preserve as a precious commodity those parts of the infirm man which are still active faculties? Or is the nursing home only a place where terminal care is provided? I would assume that the nursing home is more than this.

Involved in providing integrated services is long-range planning. Testifying on this need, Dr. Morton J. Goodman, of Portland, Oreg., said:

> When an older person leaves the hospital after an acute illness and he is unable to return to his own home or former living arrangements, he usually enters a nursing home. Here in a strange and new environment, he is lonely and frightened and is removed from familiar faces and personal possessions. He heads off and withdraws unto himself, feeling that he has been shelved by society, and he becomes in a short time a psychological, as well as a physical, invalid. It is at this point or before it that comprehensive planning for his future care should be started. It is here that the services of skilled social service workers are needed, who in cooperation with medical advisers can select the best care modality that is available in the community through supervised, progressive care planning as the patient's status changes.

The range of services should include not only physical care and rehabilitation, Dr. Goodman continued, but "occupational therapy and sheltered workshops, attention to recreational, social, and spiritual needs of these people, will be a part of the broad and comprehensive care plan."

Where such programs have been undertaken they are immensely successful and have been directed by a single agency, usually centered in a hospital. Dr. Goodman cited the enlightened care programs for the aged in Scandinavia where—

> * * * the magnificent and wonderful new institutions, the homes for the aged, the nursing homes, and homes for the chronically ill, the hospitals, and apartment houses participate in a superb quality of medical and personal care, all financed by their social security programs.

A witness at the Boston hearing on nursing homes suggested one approach that should be taken to provide the network of services needed by nursing home patients.

> I have found that many proprietary nursing home operators would like to raise the level of care, but they do not have the training or resources to do this. I feel that to raise standards of nursing home care, one must mobilize community resources to assist the nursing home in this task.

Part of the problem Dr. Leon Taubenhaus, director of the Brookline, Mass., health department, has found is that—

> Proprietary nursing homes unlike almost any other type of medical care institution, are isolated from community health resources. This is due to their historical development. Because they originated as commercial enterprises set up by nonmedical entrepreneurs, they were ignored and looked down on by the medical profession and hospitals. As a result of this original rejection they are still insulated from the hospital and the medical profession. They are often regarded by those who could help the most as a necessary evil.

A brighter picture has been painted by another witness appearing before the Subcommittee on Nursing Homes in Hartford, Conn. The testimony of this witness also indicates that it is not always necessary to look at what has been done in other countries to see a truly comprehensive care program in operation. "The key themes are rehabilitation and preventive medicine," stated Mr. Martin Freeman, president of the Connecticut Association of Nonprofit Homes and Hospitals for the Aged.

The type of home for the aged discussed by Mr. Freeman makes them—

> * * * part of the social work community, and as such, [they] are integrated into the communal social service resources. Community leadership is always involved in both planning and process. Volunteer services, on a wide scale, insure varied and personal services to residents that most happily enrich the lives of the residents. We are dependent on community philanthropic support and must, therefore, do an effective job of care if the public is to continue its interest and support. Boards of directors, in conjunction with professional staff, plan constantly to enhance standards and meet new needs as they arise.

Mr. Freeman, as administrator of the Hebrew Home for the Aged in Hartford, stated the philosophy of care in his home:

> Every person coming to a home for the aged is actually or potentially an intensive nursing case. Conversely, to the modern home for the aged, every infirmary case is a challenge to restore him to as much functioning as is realistically possible through coordinated rehabilitative efforts.

To put this philosophy into practice, the Hartford Hebrew Home for the Aged has both a chronic and an ambulatory wing with medical

service available at all times. The full range of services provided by this home include regular and frequent medical examinations, and—

> Full-time physiotherapy, occupational therapy, recreational direction, dental clinics, chiropody, X-ray facilities, social casework services, dietetics, religious services, beauty parlor service, and so forth * * *.

An example of the kinds of additional services that should be provided in all nursing homes is found in San Diego, Calif. There a therapeutic activities project has been undertaken with the assistance of National Mental Health Act funds. An expert witness appearing before the field hearing in Los Angeles described this project as one in which—

> There is total community involvement by the use of volunteers, church groups, Girl Scout and Brownie troops, and senior citizens themselves, who go into the homes to provide entertainment and purposeful activity.

A 10-week training program is given to volunteers. One proposal to expand this program is to have a traveling teacher accompanied by volunteers who would move from home to home and receive their training on the job.

Using another approach a Portland doctor has been working on an experiment of taking piecework to nursing home patients; this experiment has evoked a great deal of enthusiasm.

With the assistance of the American Red Cross and the Visiting Nurse Service a training course for nursing home attendants was set up in Brookline, Mass. An improved patient care program, including recreational programs, was the result of this undertaking. The nursing homes cooperated by sending their personnel, who continued to receive their regular pay, to the training course. This type of program deserves serious consideration by persons concerned with improving patient care in nursing homes.

The Brookline Health Department efforts in this field also resulted in making available to nursing homes, without charge, portable dental equipment, including an X-ray machine. This service includes delivery of the equipment.

Describing the dental needs of nursing home patients, Dr. Franklin Foote, commissioner of the Connecticut State Department of Health stated:

> Dental problems still are largely ignored in most nursing homes. I have seen persons with fractured teeth or roots that need extracting, fillings needing replacement, dentures that need repairing or replacement. Some of the better homes are meeting these needs, and others are arranging for portable dental equipment and for visits from dentists. * * *

This witness pointed also to the interrelationship of nutritional and dental problems, for "missing teeth means that for some the food needs to be pureed or blended." [10]

The assistance of trained dietitians, which not all homes are large enough to support, can come from hospitals as has been done in Brookline, Mass. There the hospital nutritionist acts as a consultant

[10] For a detailed discussion of the dental needs of the aged, see p. 40.

in one nursing home to review the menus. Larger homes can employ their own dietitians, and, in turn, assist smaller homes to employ a dietary consultant.

Such specialists as dietitians, dentists, and therapists, however, are in short supply generally, and nowhere is this shortage felt as keenly as by nursing homes. A part of the problem of incorporating the services of these specialists into the services provided by nursing homes is to find means of training and interesting additional people in nursing home work. Federal programs to increase the number of medical personnel have helped to fill the gap. Efforts should be made, in addition to these programs, to determine how Federal assistance might be provided to similarly help train all the other various types of personnel needed for nursing home care.

Increased efforts on the part of the States to train nursing home personnel should also be encouraged. Programs such as one in Connecticut, conducted by the State department of health, can be imitated and expanded. That program is a training institute held for 2 weeks to instruct nursing home operators and volunteers in recreation techniques. Eight institutes have already been held with 93 operators and 55 volunteers receiving training.

Connecticut's experience points to one method by which nursing homes are made an integral part of health services. There, one agency, the division of hospitals, inspects not only the 36 general hospitals, but the 22 nursing homes, the 10 chronic disease hospitals, and some 260 homes for the aged. Involved in this function is a medical director, an engineer, an architect, and five nurse-inspectors. Two advisory councils assist in the task, and the membership of these councils include distinguished professional people. The Connecticut Health Department also is concerned with programs that can be carried on for people living in their own homes and is "interested in increasing organized home care, visiting nurse services, and meals-on-wheels programs." The Connecticut Health Department also works closely with the department of mental health.

The Brookline, Mass., experience as explained by Dr. Taubenhaus provides insights into how to develop administrative techniques that will assist in integrating community health resources on behalf of nursing homes. The local health department can work with hospitals, schools of nursing, social workers, and private medical and public health personnel. The Brookline Health Department director set forth four objectives he hopes to see attained by his own local health department:

> (1) Develop continuing training courses for all levels of nursing home personnel.
>
> (2) Provide consultation services to nursing homes. These will include medical care, nursing, nutrition, administration, housekeeping, bookkeeping, purchasing, et cetera. We will lean heavily on the Peter Bent Brigham Hospital for many of these services, but will also utilize personnel from the health department as well as other organizations.
>
> (3) Coordination of community health agencies to help nursing homes develop programs leading to better patient care. Many categorical health agencies such as those interested in diabetes, cancer, heart disease, arthritis, and tu-

berculosis share an interest in nursing homes along with such general agencies as hospitals, visiting nurse associations, and rehabilitation groups. We will try to utilize their interests to develop specific demonstration programs in individual homes.

(4) Train selected patients for self-help projects within the home. This will not only be beneficial to the patient as a form of occupational therapy, but it will also free trained personnel to carry out other patient-care duties in the home. This type of program has been quite successful in veterans' hospitals and should apply to nursing homes as well.

This discussion of nursing homes can well end on the hopeful observation that we do know what it takes to make an "ideal" nursing home. Miss Geraldine Pearson of the Mount Angel College Institute of Gerontology has provided a useful definition:

> The ideal home might incorporate the following: Certainly skilled nursing care; clean and odorless physical facilities; physical and occupational therapy; a full, varied and well-scheduled recreational program; a religious program allowing services in the home and clergy visitation; encourage community dining; some type of patient responsibility; liberal visiting hours to encourage, not only a close family relationship, but also a close relationship between administrator and family so that communication is maximum; adequate visiting time by members of State agencies, for example, social workers; opportunity for the patient to have personal belongings with him; personal appearance of patients maintained; privacy for the patients; an attitude of respect for individuals on the part of each staff member.
>
> The home should be large enough to allow for the activities listed above and should have personnel that can adequately perform these duties. It should be remembered that good therapy can be done by relatively untrained persons in small areas with a minimum of equipment. All of the above suggestions can be adopted to some extent by the home. If the administrator and her staff are sympathetic with those things which can be done to better the atmosphere of the home, the home will come close to this perfect picture.

An obvious conclusion, then, is that a program of education is needed, not only for nursing home personnel, but for the families and friends of nursing home patients, for the nursing home patients themselves, and for the community groups whose assistance is needed. This educational program would be directed toward informing all these groups of what the requisites are for a good nursing home. The educational campaign might also be directed toward potential nursing home patients, that is, the public at large, so that there will be a wide understanding and acceptance of the efforts and programs required to make the nursing home an integral part of a comprehensive health care program for the aged.

CHAPTER IV. RESEARCH—A KEY FACTOR

Scientific research—the production of systematic, verifiable, and dependable knowledge—has been a key factor in giving to nearly all of us the expectation of longer and richer lives. Research is also a basic means through which we shall ultimately find ways to give positive significance to the added years of living and to make the necessary adjustments to the numerous and severe problems created by the phenomenal increase in our older population with its special needs and circumstances.

The brilliant record of research

It is the brilliant record of research in the basic biological sciences and in public health and medicine which has led to the control of infectious disease and to improvement in nutrition and in the sanitary environment. It is these factors that have added more than 20 years to average life expectancy since the turn of the century, and that, with the promised control of chronic conditions, will continue to extend the length of life. It is the equally phenomenal record of research in physics, chemistry, and agricultural and engineering technology that enables the country to sustain the rising older population. It provides the capacity to free them from the grinding poverty and misery of the majority of older people in earlier types of economies. It is to the great credit of the Congress that it has steadily and increasingly supported these research efforts over the long period of years necessary to produce the results we are now achieving.

THE NEW ROLE OF RESEARCH IN AGING

As was pointed out by our predecessor, the Subcommittee on Problems of the Aged and Aging in its 1961 report, "Action for the Aged and Aging":[1]

> It is a truism in science that, while the discovery of knowledge confers benefits upon man, it also leads to new problems and new frontiers for study and investigation. Some of our older people are enjoying the fruits of longer life—in prolonged physical and mental vigor, in adequate incomes and housing, and in rich and rounded lives. But for the majority, the later years, as the subcommittee has frequently reported, are characterized by long-term illness and disability, by loss of physical and mental power due to the aging processes, and by the host of social and economic problems revealed during the subcommittee's investigations. Beyond this, millions of families, thousands of communities, and the whole Nation are confronted with problems arising out of the rapid extension of life and the growing numbers of older people.

[1] "Action for Aged and Aging," Report No. 128, 87th Cong., 1st sess., pp. 79–80.

The subcommittee is convinced that these problems and conditions exist largely because of lack of knowledge of how to resolve them—because the expansion of knowledge has failed to keep pace with the increasing length of life, with technological developments, and with social change. One of the basic convictions of the subcommittee is, therefore, that there is immediate need for a greatly expanded research effort aimed at providing the basis for health and vigor throughout the added years; for the preservation of psychological capacities; and for the creation of social and economic conditions that will enable older people to continue as active, contributing members of society.

The subcommittee believes that almost every major scientific field—the physical sciences, the biological, the psychological, and the broad spectrum of social sciences—is involved in the discovery of knowledge that will help all of us to achieve rich, satisfying, and healthy lives as well as longer ones.

The committee believes that these findings of its predecessor body are no less valid today than when they were first set forth.

WHERE THE LACK OF RESEARCH IS LETTING US DOWN

The committee has been encouraged by the increase—slow but continuous—in expenditures on behalf of older people by Federal, State, and local governments and by scores of voluntary agencies. The aggregate amounts run into billions of dollars annually. The committee is still concerned, however, as to the kind and quality of information on which expenditures and programs are based. There is danger that action may be based on fictions rather than facts, on preconceptions rather than well-established principles, on tenaciously held prejudices rather than demonstrated knowledge. The fault may well lie not so much with those who develop and administer programs as it does with the lack of scientific knowledge available to them—a lack of such knowledge as would flow from soundly conceived and well-conducted research into the nature of the problems to be resolved or alleviated by the expenditures.

In recognition of the importance of sound knowledge on which to base programs, the subcommittee undertook in 1960 an inquiry into the status of research on the problems of the aged and aging. A questionnaire was sent to a large number of acknowledged experts in the field.[2] Two subcommittee staff meetings, much like postgraduate seminars, were held on October 4 and 5 of 1960, the first of which was attended by some of the leading scientists working on the medical-biological aspects of the aging and the second of which included outstanding social scientists engaged in gerontological studies. Also available to the subcommittee were the recommendations of the scores of scientists and specialists who participated in the White House Conference on Aging in January 1961 and in the dozens of State conferences which preceded the national meeting.

[2] Ibid., "App. I—Questionnaire on Research in Aging," pp. 129a–250.

The subcommittee found that such knowledge as there is in the field of aging is too narrowly disseminated and inadequately used. It found relatively few attempts to make use of knowledge from related fields that have direct bearing on the field of gerontology. It found that much so-called research in the field is second rate, carried on by poorly trained and undersupervised personnel or by individuals not trained in research techniques at all.

It found that great problems exist insofar as the recruitment and training of personnel for teaching and research in gerontology are concerned. It uncovered problems relating to the financing of research in the field of aging that are directly responsible for many of these shortcomings and for the haphazard development that has characterized the entire field of gerontology. And it found that the financing of the research we must have, if we are to act wisely in this field, is inadequate.

In the more than 2 years that have elapsed since the subcommittee explored the status of research, only a few encouraging developments have been noted. The subcommittee's findings as to research gaps and inadequacies are equally valid today. Therefore, the pages that follow in large part repeat and underline the findings reported in 1961, with an occasional reference to more recent developments. The status of research is virtually unchanged, despite an increasing urgency in the demands of program administrators and action groups who, countrywide, are looking for direction and sound guidance in the development of necessary facilities and services.

RESEARCH ON AGING TODAY

Research on aging—gerontological research, as it is called in academic circles—is relatively new. In consequence of its newness and of other factors, research in gerontology is handicapped in establishing itself as a field to which outstanding men and women can devote themselves with any certainty of a secure future, suffers from serious imbalances of emphasis, is gravely short of personnel, and is decidedly underfinanced. These points are explained below.

Slow development of research in aging.—Over the first half of the century, research has given us an enormous amount of knowledge about the growth and development of children and about the nature and problems of adolescence. More recently, there has been a growing volume of research on the physical and mental health, family relationships, and the influences of environmental factors of young adults. Research on the later stages of life—on aging and old age—got underway only a few years ago and then as a matter of scientific curiosity on the part of a few biologists and psychologists. It is only now being recognized that almost everyone will live into the advanced years and that the processes of aging, the problems of older people, and the challenges to society are vastly different from those of youth, and equally numerous and complex.

It is distressing that so few scientists in the basic disciplines—biology, biochemistry, physiology, psychology, economics, sociology, and political science—have foreseen the need to extend their studies and teaching to a consideration of the aging organism and the problems of older individuals. They have been slow to set up courses on aging

within their fields. The subject matter of aging is generally nonexistent or is buried in courses on other topics.

Until there is impetus from the top—until aging is recognized as a national challenge and concern—experts agree that the colleges and universities will continue to be backward in affording gerontology a recognized position within the curriculum.

The importance of interdisciplinary studies.—Some of the most serious problems now affecting research in gerontology are inherent in the compelling and inescapable fact that this field cuts across many other areas and requires an interdisciplinary approach. The processes and problems of aging affect virtually every aspect of human life. No single facet of life can be fully understood without reference to others. This is particularly true among older people whose health and mental well-being, for example, are vitally related to their incomes, the activities in which they engage, the place society accords them, and to a variety of other factors. Thus, while there is great need for research on aging within particular scientific fields, there is even greater need for research carried on by teams of researchers from several related fields working in close harness on single, but many-sided, problems.

To the extent that gerontology becomes a recognized field, researchers will appreciate the sterility of approaches that undertake to compartmentalize the individual. They will not study his behavior and needs within unrealistically narrow areas, apart from the environments within which he lives and in ignorance of the multitude of problems with which he is confronted.

Inadequacies of current research in aging.—Because the field of aging is new and because financing is inadequate and inappropriately handled, far too much of today's research is notoriously superficial and short ranged. Biological and physiological aging is rooted in the most fundamental organic and chemical structures and life processes; psychological aging is a complex product of biological, mental, and sociological changes; the behavior of older people is a product of habits developed over a lifetime and of an enormous variety of biological, cultural, and environmental factors and influences.

In recognition of these facts, it was the overwhelming conclusion of those whose opinions were solicited by the subcommittee that gerontological research must be pursued both in depth, over long periods of time, and with sufficient numbers of subjects to give validity to the findings. It was the conviction of these scientific leaders, forcefully underwritten by participants in the White House Conference on Aging, that it is only through long-term, longitudinal studies (studies of the same people over long periods of time) that we shall ever come to a real understanding of the nature of the aging process and of the social and economic implications of aging in modern society.

Specific problems arise in the study of animals because of the cost and difficulty of obtaining adequate supplies of old animals. The difficulties of studying the processes of aging in humans are far more complicated and costly because of the much longer time periods involved, the greater number of variables, and the obstacles in the way of obtaining representative populations of middle-aged and older people. One respondent to the subcommittee questionnaire characterized such research as—

> large-scale experiments that will be required in many instances to detect the small-scale effects involved in many of the phenomena characteristic of the aging process.[3]

Another of the many recommendations on the need for long-range studies in gerontology stated the problem in these terms:

> It is an essential feature of research financing, especially in the aging field, that support be given for a sufficient period of time to enable the investigator to carry out a penetrating study. Often, this will require a period of several years, and it may be only after numerous disappointments that fruitful results are forthcoming.[4]

The alternative to providing adequately for the long-range studies is likely to be that the researcher—

> may limit his research to problems from which he expects to get very rapid results, and use methods which are not the most desirable but which will give him some kind of data to use in a research report so that he can apply for another short-term grant.[5]

In recommending the long-range studies, the seminar participants discussed the length of time required for the studies that should be undertaken in terms of 5-, 7-, and 10-year periods. Studies that extend for 20 years or across an entire generation are also required. Such studies are all too rare today.

A related problem arises because research grants are often so small that scientists cannot include enough subjects in their studies to make their findings valid and reliable. All too frequently, the studies reported in books and scientific journals are based upon fewer than 100 cases. It is absurd to allow ourselves to believe that we shall have sound and usable knowledge until research workers are able to reflect in their sample populations the great variety of individuals and situations found among our 55 million middle-aged and older people.

The acute shortage of teaching and research personnel.—Scientific knowledge is not produced by untrained investigators or by robot computers. Now, more than ever before, we are dependent upon the imagination, insight, skills, and patience of highly trained investigators thoroughly sophisticated in the subject matter of gerontology and in the fields which contribute to it.

Serious handicaps to research on aging today lie in the lack of qualified personnel devoting their energies to the field, in the roadblocks to the recruitment of young people to the field, and in the scarcity of university faculty members with knowledge of aging to teach those who do show interest.

The Gerontological Society, the sole professional organization in the field, has only 2,300 members of whom well under half are university teachers and working scientists. In contrast, the American Psychological Association has more than 18,000 members; the Ameri-

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[3] Alexander Grendon, Coordinator, Office of Atomic Energy Development and Radiation Protection, Governor's Office, Sacramento, Calif.

[4] Dr. H. H. Draper, associate professor of animal nutrition, College of Agriculture, University of Illinois, Urbana.

[5] Dr. Robert B. Johnston, associate professor, Department of Chemistry, University of Nebraska, Lincoln.

can Sociological Association, 6,700; the American Psychiatric Association, 12,000; to mention a few of the professional groups concerned with the understanding and treatment of human problems. The simple fact is, that notwithstanding the immense challenge presented by the existence of almost 18 million older people in the United States about whose characteristics and needs we really know very little, the field of gerontology has not yet caught on.

The factors underlying this situation are several. Gerontology is—according to one respondent to the questionnaire—

> * * * in competition with some very expensive studies in the physical sciences, which have high prestige, and consequently have big donations made to them. As one thinks of the whole of human society he will probably and finally conclude that human welfare is the foundation on which all research should be based. The whole of human welfare should be better financed and on a broader foundation than at present.[6]

Another subcommittee respondent stated that—

> Researchers in aging do require special attention to keep them in a field which hitherto has not been particularly rich in experimental findings and in which difficulties are encountered as great if not greater, than those occurring in cancer research.[7]

A corollary to the problem of attracting some of the highest ranking research people to gerontology is the fact that the quality of research in the aging field has not always met the highest standards. As one witness stated:

> Up to now there has been some excellent biological research and much mediocrity. The various papers on aging that I have read, with notable exceptions, are notoriously poor.[8]

A prevailing opinion among the participants in the medical-biological seminar was that gerontology research is in the same position cancer research was in prior to the establishment of the National Cancer Institute. That is, cancer research suffered from second-rate and haphazard efforts until the National Institute undertook the task of organizing and directing research in the field. It was only then that some of the best qualified researchers were drawn into the cancer studies.

Another factor lies in an obvious oversight of the need to determine how many teachers and researchers are needed in the field of aging, to define precisely the kinds of personnel required, and to identify and enumerate positions open to those who might elect to work in the field. Until such information is developed—as it has been with reference to almost every other professional field—it will be difficult to attract young scientists to it.

Closely related to this matter is the need for giving encouragement to students in the form of scholarships, fellowships, and stipends; for training present faculty members in aging; and for giving recognition

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[6] Dr. Chester Alexander, Westminster College, Fulton, Mo.
[7] C. J. Leblond, Department of Anatomy, McGill University, Montreal, Canada.
[8] Dr. William Montaga, Department of Biology, Brown University, Providence, R.I.

to the field through the establishment of courses and research facilities.

As has been the case in other areas, the acute shortage of personnel is most likely to be corrected if and when the Federal Government exercises vigorous leadership to demonstrate its concern with the importance of good teaching and research in this area.

Federally supported research.—Federal agencies have been responding, albeit slowly, to the pressures for scientific information about the processes of aging and about older people and their circumstances. Several departments and agencies, notably the Department of Health, Education, and Welfare, the Department of Agriculture, the Department of Labor, and the Veterans' Administration are themselves conducting increasing amounts of research on aging and two are making grants to universities, professional schools, and other outside research centers.[9]

The National Institutes of Health within the Public Health Service (Department of Health, Education, and Welfare) is the principal Federal agency involved with research on aging. The Institutes maintain a center for research on aging which undertakes to stimulate interest in research in this field, provides a focal point for information on aging within the Institutes, and is currently making some grants. Located, until recently, within the Division of General Medical Sciences, it necessarily has had a medical orientation. In appraising the work of the NIH on behalf of the aged, Dr. G. Halsey Hunt, former Chief of the NIH Division of General Medical Sciences, notes that—

> The NIH programs are quite broad, extending from the molecular level at one extreme to the social level at the other, including, of course, a great number of studies into the chronic diseases which so often characterize old age. All biological and medical disciplines are represented.[10]

While no funds are earmarked for research on aging, the Institutes are currently supporting approximately 900 grants to outside agencies for research and training which are either primarily or secondarily related to aging and problems of aging.

One of the promising developments of the past year has been the creation of a National Institute of Child Health and Human Development within the National Institutes of Health. It is in this Institute that the Center for Research on Aging is now located. This committee hopes and expects that this new Institute will proceed to develop a major research program on aging and serve to greatly expand the program of the National Institutes for grants for research and teaching in aging.

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[9] The Housing and Home Finance Agency received, for fiscal year 1962, the sum of $125,000 to reimburse the Bureau of the Census for special tabulations of 1960 census data on the housing conditions of persons 62 years of age and older. These tabulations now are complete. The committee believes that HHFA should undertake a much broader program of research, particularly with respect to housing problems and preferences of the elderly. For a further discussion of research in housing, see ch. III.

[10] "Research Highlights in Aging," Public Health Service Publication No. 779, Washington, D.C.: Government Printing Office, 1959, p. iii.

One of the notable activities of the National Institutes of Health is the support of five research centers all of which are presumably concerned with relatively broad aspects of aging. These are at—

Duke University Medical School (Durham, N.C.) 1957.
Yeshiva University, Albert Einstein College of Medicine (New York, N.Y.) 1958.
Western Reserve University Medical School (Cleveland, Ohio) 1960.
University of Miami Medical School (Miami, Fla.) 1960.
Brown University (Providence, R.I.) 1961.

It is interesting to note that all of these centers are either located in medical schools or are under the direction of medical personnel. There is rising support for the recommendation of the delegates to the White House Conference on Aging that there be established regionally distributed institutes of gerontology with a central focus on research in the psychological and social sciences. Such institutes are in existence at the present time but they are largely paper organizations because they are not being supported with grant funds as are those in the medical schools.

Within the National Institutes of Health, there are two research units devoted to studies of aging in the individual. The Gerontology Branch of the National Heart Institute, established in 1941, has achieved eminent status as a pioneer and sustained contributor to a continuing program of research on biology and cellular physiology, human physiology, human work performance, human psychological performance, and geriatrics. The section on aging within the National Institutes of Mental Health is studying the behavioral changes which accompany aging through observation of the aging process in animals and humans in order to reveal and understand our physical and mental aging process.

While the approaches in both of these centers involve the correlation of biological, physiological, and psychological aspects of aging—thus pointing in the direction of essential interdisciplinary research—neither center has, as yet, given much attention to the cultural, economic, and social factors in aging.

Mention should be made, however, of the fact that the Public Health Service, through its Bureau of State Services and using funds authorized by the Community Health Services and Facilities Act, is supporting research which has a direct bearing on the health care of the aged. One particular significant activity, financed through a grant from the Service, is a research project currently being directed by the Group Health Association of America. This is a long-range, "practical" study to develop detailed knowledge about patients of prepaid, group practice medical care plans in the United States, the treatment they receive, and their future needs. One anticipated result of this study should be an improvement of out-of-hospital services for the chronically ill and aged.

The Department of Agriculture has a program of research on nutrition, clothing, home design, and facilities in which it gives special attention to the needs of aged and handicapped women. Through its own studies and through grants to land-grant colleges and universities, it is supporting some studies on the financial circumstances of

older people, adjustments in retirement, and the adequacy of public services in rural areas.

The Department of Labor makes continuing or periodic studies of older worker employment, effects of technological change, pension agreements, and costs of living. Several years ago, it conducted a study on the performance of older workers and another on the experience of older workers in public employment offices (see p. 48). Toward the end of 1960, it published a new budget for elderly couples which was priced in 20 large cities, but in no small cities or in rural areas.[11] Lack of detailed knowledge of the budgetary needs and expenditures of retired people is one of our most serious gaps.

The number of patients 65 and over in Veterans' Administration facilities has increased more than tenfold over the past 20 years. By 1965, 40 percent of the VA resident patient load will be in this age group.[12] VA hospital and domiciliary facilities will be overwhelmed unless research on chronic disease leads to the prevention or cure of a good many cases and unless social research leads to discovery of ways in which handicapped older veterans can continue to live independently in the community. Obviously the enactment of a social security based health insurance program for people over 65 would serve to relieve much of this anticipated pressure both on VA facilities and on the general revenues.[12a] The Veterans' Administration currently has a number of research projects on aging underway within its facilities.

Many Federal agencies collect and publish statistics related to the older population. These include the Bureau of the Census, the Social Security Administration, the Department of Labor, the Veterans' Administration, the National Office of Vital Statistics, and the Public Health Service through its increasingly useful national health survey. Both the Bureau of Family Services and the Bureau of Old-Age and Survivors Insurance make periodic studies of the characteristics and circumstances of samples of their older beneficiaries.

The Social Security Administration has a program of grants for research and demonstration projects in the broad field of prevention or reduction of dependency and improvement of social security and related programs. Among the projects receiving grants are a longitudinal study of retirement, an investigation of decisions leading to the institutionalization of the aged, and a pilot study of nursing home costs.

Today, just as in 1961, our overall appraisal of Federal research activity in aging is that there is increasing interest in the field but that it is far from keeping pace with the increasing size and problems of older persons. We are still concerned about the lack of any overall stimulating and coordinating agency within the Government to assess research needs and progress, identify gaps, and develop recommendations for further advances. This, too, is one of many reasons why we

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[11] "The BLS Interim Budget for a Retired Couple," Monthly Labor Review, November 1960.

[12] "How the Government Works for Older People," 1962 Report to the President of the Federal Council on Aging, p. 97.

[12a] The Social Security Administration estimates that passage of the administration's bill would make possible a saving of approximately $75 million of VA funds during its first year of operation. This, of course, would be increased as more and more veterans reached the age of 65.

urge the creation of the U.S. Commission on Aging discussed more fully in another section of this report.

There still remains a definite need to earmark funds for research, and for the training of research workers and university faculty in aging. It is high time we recognize the need for research on the economic, social, and welfare aspects of the field of aging.

Privately financed research.—The past decade has seen some increase in the amount of research on aging supported by private funds, mainly from foundations (such as the National Cancer Society) with some interest being shown by a few of the more general foundations. Most of this research is being done in hospital laboratories and universities.

It is only comparatively recently that the nonspecialized foundations have begun to support research in the economic and social aspects of aging. And most of this focuses on immediate problems and social welfare rather than on basic research essential to the accumulation of fundamental knowledge and understanding.

The development of foundation interest in aging has been traced by Dr. Thomas H. Carroll, former vice president of the Ford Foundation, in his address to the White House Conference on Aging.[13]

Dr. Carroll quotes two recent studies of the current activities of the foundations. Twenty-four foundations indicated aging as an area of interest, although none listed aging as its primary program objective. The largest portion of their grant funds goes for research purposes and for demonstration projects; only a small part goes for training funds or grants for care. In 1957, these 24 foundations made grants totaling $1,273,000 in the aging area. This amount represented 6 percent of the $22 million given for social welfare purposes that year by 67 of the largest private foundations. Interestingly enough, youth agencies and projects dealing with deliquency received more than 27 percent of the private funds from these foundations during that year. The Ford Foundation's activities, as set forth in its 1961 annual report, included projects to improve community planning, job-placement services, and living arrangements for the elderly, and to strengthen training of social workers in the problems of the elderly.

An effort to enable older persons to continue living in their own homes, thus avoiding the dislocations and costs of institutional care, was assisted by a $300,000 grant to the Family Service Association of America. The grant will finance a 4-year program to help privately supported family agencies strengthen their counseling and home-care services and train their staffs in new concepts and techniques. It complements a grant made in 1959 to improve the services of public agencies dealing with the elderly. To carry out the program, a team of professional experts will work actively with 30 local communities selected as demonstration centers.

An appropriation of $140,000 was made for the establishment of a national association of nonprofit homes for the aged.[14] Sponsored

[13] "Aging With a Future," reports and guidelines from the White House Conference on Aging, "A National Foundation Expresses Its Interest in the Problems of Older People," pp. 125–128.

[14] See p. 116 of this report for a further discussion of the association.

by the National Council on the Aging, the new association seeks to raise the standards of care and services for older persons in institutions.

Eight pilot projects to help local planning councils in urban and rural areas make better use of funds available for the needs of the elderly will be supported by grants from a new $460,000 appropriation. The projects will demonstrate improved budgeting and planning. They supplement seven experiments, supported by the Ford Foundation last year through grants coordinated by Brandeis University, on ways to strengthen the organization of local programs and facilities. Western Reserve University, aided by a national advisory group, is serving as a research and evaluation center for the new projects. As in the earlier series, knowledge gained from the projects will be disseminated through manuals for local voluntary and public agencies and through case studies for professional schools.

To help social work students better understand the problems and potentials of older people, a grant of $160,000 was made to the Council on Social Work Education for the preparation and distribution of case studies, films, and other teaching materials. The new materials will be used in inservice training as well as in graduate and undergraduate studies.

Washington University (St. Louis) received a $177,000 Ford Foundation grant for a study of public and private job-placement services for middle-aged and older workers and of retraining programs and other efforts to increase their employability. The results will be disseminated through case histories of successful programs and seminars for employment officials.

Grants for research and demonstration projects in aging made by other foundations include a Rockefeller Brothers' grant of $300,000 to the Community Services Society in New York. The Kellogg Foundation has supported services in homes for the aged in Michigan and also has supported the Battle Creek Community Council. The Lilly Endowment in Indianapolis has supported a welfare council there. The Babcock Foundation granted $70,000 to the North Carolina State Department of Public Welfare to do research in aging.

A few community foundations have granted funds in the field of aging. The Hartford Foundation for Public Giving, for example, first gave a grant to a local committee on aging for use in developing plans for community services; thereafter, the foundation provided support to initiate these services, including a homemakers service and a home placement service for older people.

The American Public Welfare Association has for several years now had a project on aging, supported by the Ford Foundation, for the purpose of helping State and local welfare agencies to meet the social, economic, and health needs of the aging. Through seminars and publications, this project makes it possible to convey essential information to key public welfare personnel whose responsibilities include the aging. In April of 1962, APWA's project on aging received from the Ford Foundation an additional grant of $800,000 for a 6-year program to develop and demonstrate training programs for public welfare personnel dealing with elderly people. Under the new grant, major attention will be given to: (1) The training of administrators and supervisory personnel to insure that they get the best services

possible from their staff members working with the elderly; and (2) the development and demonstration of inservice and academic programs to raise the competence of service staffs dealing with older people.

The National Council on the Aging has several research projects underway which merit special attention. One of these is a project on principles and criteria for determining medical indigency. This project was initiated in August 1961 under a grant from the Frederick and Amelia Schimper Foundation.

In mid-1962, the National Council on Aging announced a new study of portable meal programs, financed by a grant of $39,343 under the Community Health Services and Facilities Act. The study aims to answer the question: "Will house-to-house delivery of prepared meals help the situation of the chronically ill or older persons?" The council project will make recommendations on whether programs that bring prepared meals to living quarters of persons who cannot care for their own dietary needs are a necessary part of out-of-hospital community services. It will set guidelines for this kind of program and criteria for determining the need of the individual for these meals-on-wheels programs.

In answer to the subcommittee's questionnaire, researchers reported a number of limitations in working with funds from private sources. It is said to be rare that "private foundations give anything but year-to-year grants and this makes it difficult to plan a long-term study." [15]

Comments on privately financed research in the field of aging indicated that such research today is similar in many respects to research in the health fields during the thirties and early forties. Illustrative of this are the following:

> Foundation support has tended to be somewhat erratic and almost whimsical. * * * My impression is that the foundations have tended to support "safe" projects which will maximize a positive public image of the foundation's interest in urgent social problems.[16]
>
> Private foundations are impatient for results.[17]
>
> Longitudinal studies covering long periods of time are essential in aging research. These kinds of studies can rarely be supported by private foundations, even though they are of great importance.[18]

Other comments point to the necessity for Government leadership in recognizing and supporting research in gerontology and in the problems of aging. The following comments are illustrative of the belief that public support is essential to large-scale development of the field:

> The great achievements of medical research in the last decade are undoubtedly due to a major degree to the important role played by Government support. * * * As experience has shown, such Government support tends to encourage—

[15] Dr. Geoffrey H. Bourne, Division of Basic Health Sciences, Emory University, Atlanta, Ga.
[16] Dr. Gordon F. Streib, Cornell University, Ithaca, N.Y.
[17] Dr. Otto Pollack.
[18] Dr. K. Warner Schaie, University of Nebraska, Lincoln, Nebr.

not discourage—private foundations' investments in aging research.[19]

Since, in my opinion, the Nation's brainpower is one of its most precious national resources, I think it is imperative that long-range investments in able scientists be made.[20]

State and local interest in research.—The reports and recommendations of the State Governors' conferences held in connection with the White House Conference on Aging have afforded information on the status of research in gerontology in the States. Many of the States have made reports very similar to these comments from Kansas:

> The amount of research on aging (social science and psychology) which has been completed in Kansas is minimal. The obvious reason for this condition is the relative newness of aging as a matter of public concern. In the event the State establishes a commission on aging or a center for the study of gerontology, the number of research projects in the field may be expected to increase markedly.[21]

The Alabama report on social and psychological research in gerontology stated that—

> according to the subcommittee on research, the colleges and universities of the State report almost no research at the present time on problems of the aging and aged.

One medical research project was reported.[22]

From Illinois came the observation that—

> Federal and State Governments and private sources of financing will have to be educated to the necessity of financing longitudinal studies if we are to attain some of the goals in research on aging.

As expressed by one State, the special problems are that—

> Illinois shares with the rest of the Nation a need for more competent persons in the field of research and the funds to enable them to do a productive research job. The interest in research is growing, and while much has been done, there is still much to do. Long-term research projects are needed, and while they are expensive, we need consider this expense in contrast with the cost of the sums of money put into the support of older people. If we can, through research, make substantial savings by keeping a substantial number of older persons ambulatory and on a self-help basis rather than invalids, then, in the long run the expensive way may be the cheaper.[23]

More than 7 years ago, the Council of State Governments published a summary of recommendations made by State study groups that had

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[19] Dr. Jeremiah Stamler, Board of Health, Chicago, Ill.
[20] Dr. Arthur C. Upton, Oak Ridge Laboratory, Tennessee.
[21] "Kansas Recommendations on Aging," prepared by the Kansas State Interdepartmental Committee on Aging, p. 33.
[22] "Alabama Preliminary Report on Recommendations to the 1961 White House Conference on Aging," June 1960, pp. 25–26.
[23] Illinois Advisory Council on the Improvement of the Economic and Social Status of Older People, "Recommendations and Summaries of Reports," September 1960, p. 31.

examined the research needs of gerontology. These recommendations included—

> *Basic research.*—Research on the biological, economic, and social aspects of aging needs to be increased and intensified by grants from Federal agencies and private foundations and appropriations from the States.
>
> *Financial support for research.*—A national foundation on problems of the aging should be established to plan and support a comprehensive program for research and to support demonstration projects for the welfare of the older persons.[24]

When the recommendations to the White House Conference on Aging from all of the States were summarized, virtually unanimous opinion was found that there is urgent need for research on all aspects of aging; that personnel trained for research in aging and research facilities should be increased as rapidly as possible; and that both Federal and State Governments have a clear responsibility to support all of these activities.

Following the 1961 White House Conference on Aging, a group of Midwestern States—Iowa, Minnesota, Missouri, North Dakota, and South Dakota—gave recognition to the need for a continuing cooperative research effort through the formation of a Midwest Council for Social Research on Aging. The council was later expanded to include Illinois, Kansas, Nebraska, and Wisconsin.

The disproportionate emphasis given to medical-biological over social science research.—Basic to the problem of using research in aging to meet the current needs of the aged and aging is the necessity of evaluating the current status and scope of research in the field. There had been many indications before the questionnaire was sent out that there was a serious deficiency in the amounts being spent for all research in aging, but especially inadequate were the sums devoted to the social sciences.

Interest in the social science aspects of aging stems from the growing conviction, suggested in the opening paragraphs of this chapter, that the most significant consequences of aging do not lie in the extension of life itself but rather in how older people live, what they do with their lives, what problems and adjustments confront society by reason of their increasing numbers, and what contributions older people can make to their communities and to the general social welfare.

As stated in the 1961 report:

> The answers to these questions lie largely in the fields of the social sciences, or in what is rapidly coming to be known as the field of social gerontology. Answers are dependent in part, of course, on the physiological and health or disease characteristics of the organism itself (hence, the need for interdisciplinary studies), but the primary focus must be on such questions as what kinds of activities and responsibilities can be assigned to older people and what will they accept; what are the factors in maintenance of healthy mental outlooks; what are the effects of retirement from work, of

[24] "The States and Their Older Citizens," the Council of State Governments, Chicago, Ill., 1955, p. 95.

widowhood, different levels of income, and of various social attitudes and policies on behavior and personal adjustment; what housing, community facilities, and protective services do older people need, how much will they cost, and how should they be paid for.

In order to obtain the opinions of scientists themselves, the subcommittee sought replies to the following question relating to the balance between the two broad areas:

> To what extent, if any, is there an imbalance in amounts being spent on medical-biological research on aging as over against social science research?

The respondents were generally split on this issue with the social scientists asserting they do not receive anywhere near the amount of funds available for medical-biological studies and the physical scientists indicating a severe shortage of funds in their areas. In general each discipline emphasized the urgent, unfulfilled research needs in its own sphere.

On balance, the evidence does indicate that a greater investment must be made in social gerontology, relative to the medical-biological fields. The issue is not one of reducing the medical-biological funds, but rather, how to increase both interest in and the resources of the social sciences. Here are the examples of typical comments from social scientists:

> A major increase in support given social science research is called for, not at the expense of support for medical-biological research, but in addition to it. It appears that this increase is not likely to come from the States or private foundations, and will of necessity be given by the Federal Government.[25]
>
> I am not familiar with the budget distribution between medical-biological and social science research. However, it is my opinion that the stress should heavily favor the social aspects of aging. This answer is based on a lay appreciation of the need for sociological advancement and my dissatisfaction as a scientist with current trends in medical-biological research with respect to aging.[26]
>
> There certainly should be a proper balance between amounts spent between medical-biological research and social science research. In other words, a balance should be maintained between amounts spent on efforts to keep old people alive and what to do with them when they are kept alive. This looks like a 50–50 effort to me. Perhaps a little more spent on policy research would be wise.[27]
>
> I believe there is no question whatsoever that there is a large imbalance in the amounts being spent on medico-biological research on aging as over against social science research although the field of psychology does not fall in the category of undersupported fields. The problem is that there

[25] Dr. William H. Harlan, Department of Sociology, Ohio University, Athens.
[26] Howard B. Bensusan, M.D., Benjamin Rose Hospital, Cleveland, Ohio.
[27] Clark E. Brown, M.D., Lankenau Hospital, Philadelphia, Pa.

> is no regularly dedicated source of funds for basic or applied research in the social sciences, and the studies carried on through grants from the National Institutes of Health or other branches of the Public Health Service and the Department of Health, Education, and Welfare must come under the province of health or mental health. Although the latter is quite broadly interpreted, there is much basic research needed and being proposed which can be conceived as "health or mental health" only through a large degree of pure word stretching. A glance at any of the recent reports of the National Institutes of Health shows the large preponderance of nonsocial science research. However, the above remarks are not meant to imply that the medico-biological fields are necessarily being supported as well as they could be—I am only noting the relative lack of social science support.[28]

The above quotation also emphasizes the need for basic research in the social sciences.

In discussing the deeper implications of providing a "subject matter balance," Clark Tibbitts of the Department of HEW Special Staff on Aging has written that there is not an undue emphasis * * * given to research in the biological and psychological aspects of the field, since—

> the basic functional, health, mental performance, and personality circumstances of large numbers of older people are such as to warrant our making the most possible progress in seeking their improvement. The present problem seems to me to lie more in inadequate recognition of the need for research on equally compelling sociological, economic, and political aspects of aging.

The Director of the National Institutes of Health is in a particularly good position to observe the balance or imbalance of support for research on the various aspects of aging. Dr. Shannon had the following to say in answer to the questionnaire:

> We do not have any estimate of the proportions of research on aging that can be defined as medical-biological research or social science research. In general, support for medical-biological research has been more readily available than support for research in the social sciences. However, the National Institutes of Health recognizes that various social sciences can make vital contributions to better understanding of, and action upon, matters of health and aging. Accordingly, we feel that support for projects of comparable quality in both the social sciences and the medical-biological sciences should be equally available through appropriate Government agencies and private sources. We believe that this would lead to a natural growth in expenditures for Federal Government support of research in the social sciences, including the social science component of aging research.

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[28] Dr. Harold L. Orbach, assistant project director, Interuniversity Training Institute in Social Gerontology, University of Michigan, Ann Arbor.

In the absence of a Federal agency equipped to give adequate attention to the Government's total responsibility and programs in aging, the committee has been unable to obtain a complete analysis of Federal expenditures according to the types of projects supported. The 1960 data from the National Institutes of Health—which provide the major support for research in aging—showed that less than 10 percent of all extramural projects supported are for research and training on the social science and psychological aspects of aging. That this situation still obtains is found in the testimony of the National Institutes of Health before a House of Representatives Subcommittee on Appropriations just a year ago:

> A current analysis of these projects shows that more research emphasis on the psychological and social aspects of aging is needed. Presently, the majority of all research projects in aging relate to the physiological and biological aspects of aging.[29]

This committee is of the opinion that as long as the National Institutes of Health are providing the major leadership in gerontological research, that research will logically have its primary focus on medical-biological studies. The committee views with increasing concern the small amount of support available from Federal agencies for study of the social and psychological processes of aging and of the severe social and economic problems created by the rapidly rising number of older people. We question whether this growing gap in our knowledge of aging can be overcome until there is created an agency charged specifically with supporting research and training of personnel for teaching and research in the broad field of social gerontology.

MEETING THE NEED FOR KNOWLEDGE

The 1961 report of the subcommittee summarized the need in these terms:

> The subcommittee's findings, based on its own studies and documented by the opinions of scores of specialists from all branches of the field, lead to the simple conclusion that there is compelling need for (1) knowledge in depth which will provide a basic understanding of the processes of both individual and social aspects of aging and (2) statistical and evaluative data upon which to base sound program development involving the expenditure of billions of dollars. While the need is simple, the method of achievement is relatively complex. Involved are the recruitment and training of personnel for research and teaching; creation of facilities and conditions in which the right kinds of research can be done; and determining the proper share which the Federal Government should contribute to the costs of research. Finally, it involves a determination on the nature and location within the Government of whatever instrumentality may be best adapted to providing leadership in research and training and to administering the funds appropriated therefor.

[29] Hearings before a subcommittee of the Committee on Appropriations, House of Representatives, 87th Cong., 2d sess., U.S. Government Printing Office, 1962, p. 974.

The foregoing statement of the problem holds equally true today. The need is still the same despite the fact that we have moved ahead to recognize that only an independent high-level agency of government can provide the leadership required.

INCREASING THE SUPPLY OF RESEARCH PERSONNEL

Basic to the problem of recruiting large numbers of high-caliber personnel to work in gerontology is the necessity of identifying the field of gerontology as an important one for study, research, and teaching. It was the conclusion of both seminar groups that it lies within the power of the Federal Government to give stature and validity to the field of gerontology through the development of its own research programs and through financial support of research and training throughout the country.

Attention must be given to the immediate recruitment of four categories of personnel if we are to make the progress which is essential. These are: Teachers, scientists, research specialists and technicians, and graduate students.

Teacher.—Large-scale development of trained personnel in gerontological research requires that a sizable number of faculty members in colleges, universities, and professional schools devote increasing proportions of their time to teaching and research in this new field. Interest has appeared. There are some who are teaching a few courses and some who are doing bits of research. There are very few, however, who have thus far been willing to identify themselves wholly with the field and to devote their careers to gerontology.

The subcommittee reported in 1961:

> After listening to the participants in the seminars and after analyzing the material it has collected from a wide variety of sources, the subcommittee is convinced that there are many college and university teachers today who are eager to get into the field and who will do so once the conditions are favorable. The essential conditions, in the judgmentof the subcommittee, are:
>
> (*a*) Funds for the support of teaching positions;
> (*b*) Increase in the facilities and materials for research;
> (*c*) Encouragement for students; and
> (*d*) Assurance of support of training and research on a continuing basis.

The committee was, for a short time, gratified to learn that these convictions with regard to the potential interest of universities are belatedly and in part finding expression in a current activity of the Special Staff on Aging in the Department of Health, Education, and Welfare. Over the past several months, in an effort to carry out some of its responsibilities, as recommended by the White House Conference on Aging, the special staff on aging has been visiting universities in all parts of the country and holding meetings with faculty members and administrative officers in order to stimulate their interest in teaching and research in aging.

However, now that the special staff on aging is no longer attached to the Office of the Secretary of the Department of Health, Education, and Welfare, but has been downgraded to a nebulous status in the Welfare Administration of that Department, the widespread academic

interest which the special staff believed it had aroused can be expected to rapidly wane unless a new and more effective approach identified with a broader Federal entity moves into the area. Just as elderly Americans want to have nothing to do with "welfare," no matter how broadly the word may be interpreted, so, too, university faculty members, in other disciplines, are strongly inclined to leave "welfare" matters to their schools of social welfare. We are of the opinion that if the Federal Government attempt to stimulate academic interest in gerontology is to be fragmentarily promoted by a staff in "Welfare," another in "Public Health," a third in "Housing," a fourth in "Labor," a fifth in "Agriculture," and who knows how many other groups representing but segments of the totality, our objective of realizing a very badly needed, multidisciplinary approach to research on aging may well have been set back for a decade. If the Federal Government is so little concerned with developing a coordinated approach to the problems of aging that it is unable to voice its interest through a single body above and independent of the various departments with their varying interests, how then can we rightfully expect or ask the many schools and departments which constitute a university to do otherwise? This is but another—but a most important one—of the several reasons (set forth in more detail in chapter V) why we believe it essential to promptly establish a U.S. Commission on Aging.

Scientists.—Also acute is the need for highly trained professional personnel from widely diverse fields who will devote their full time to research on aging in a large number of centers, institutions, and laboratories over the country. Here the recruitment problems are similar to those with respect to teachers; need for research centers where teams of scientists can work together; research material; and guarantees of long-term support. The committee is in total agreement with those who point out that qualified researchers are not going to be attracted to projects supported on a year-to-year basis.

Much laboratory work in gerontology is done with animals. One of the recommendations that appeared frequently in the responses to the subcommittee's questionnaire and in the seminar proceedings was that scientists must have necessary research material for effective work, such as:

> Animal colonies of many species must be established to make available material of known ages. Lack of the latter is, and has been, a major problem for experimenters.[30]

These are some of the conditions and factors that must be recognized in giving status to the field of gerontology and in attracting highly qualified personnel to it.

Research specialists and technicians.—Among the people already working on gerontological studies, a common problem is the difficulty of securing trained assistants and technicians. This type of personnel must usually be secured from areas on the periphery of gerontology. This problem was noted by several of the respondents to the subcommittee's questionnaire and by the seminar participants.

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[30] Dr. Albert I. Lansing, Department of Anatomy, University of Pittsburgh.

Dr. Henry S. Simms, of Columbia University's Department of Pathology, noted, for example:

> * * * The financial encouragement is needed for researchers in this field both on the investigator level and on the technical level. I have personally had difficulty in hiring good technicians in competition with industry and with cancer research. I have also had difficulty in finding researchers on the faculty level because of budgetary limitations.

Provision for training, research facilities, and assurance of continuing support of research are compelling considerations in this category of personnel as in the two preceding categories.

Graduate students.—Fully as important as recruiting established faculty members and scientists is that of providing for a continuing flow of newly trained personnel to the field. The key to this matter is the undergraduate and graduate students at the point of making their career choices for training and professional work.

At the present time, very few students have opportunity to discover the field of gerontology and to recognize it as a valid field for teaching and research. Unless there are courses in gerontology within various departments (and only a few schools have these) or unless there are research projects underway which have funds available for hiring graduate students as assistants, the student is not even going to become aware of the field, much less do his thesis in it, and look forward to making gerontology his field of specialization. Here are some typical comments on the subject of attracting graduate students to gerontology:

> * * * Encouragement should be given also to enlisting the interest of graduate students, medical students, and residents in training in the field. This will increase the cost of certain projects, since a considerable amount of supervision is needed for such students, but they can learn in no better way than by doing.[31]
>
> In the case of economists, gerontology is very much a fringe subject, and, in absence of special efforts, interest in gerontology on the part of economists is not likely to increase.[32]
>
> I believe that adequate financing and support for young persons doing research on the aged will both encourage them to continue in this area and will serve to induce new personnel to enter this area of research.[33]
>
> * * * The problem is to get the field recognized as one in which a man can make a career equally as promising as those offered by the other sciences.[34]

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[31] Dr. Alexander Simon, medical director, Langley Porter Neuropsychiatric Institute, San Francisco.
[32] Dr. J. W. McConnell and Dr. Fred Slavick, School of Industrial and Labor Relations, Cornell University, Ithaca, N.Y.
[33] Dr. Sidney Goldstein, Department of Sociology, Brown University, Providence, R.I.
[34] Dr. Fred Cottrell, Department of Government, Miami University, Oxford, Ohio.

Aids to recruitment

There are various methods of recruiting the needed research personnel to the field of gerontology. Efforts to attract individuals to gerontology should, obviously, center in the Nation's colleges and universities. There are four main approaches which have been recommended by the experts consulted both by the subcommittee and the committee; that is, there should be programs to provide block grants, centers for research on aging within universities, career investigatorships, and graduate scholarship and fellowship programs.

Block grants.—Large block grants made to universities would provide a major encouragement to the stimulation of research at the universities. It has been suggested that a dozen or more of these be made as soon as possible. Dr. Wilma Donahue of the University of Michigan's Division of Gerontology has stated the case for block grants:

> Universities like the block grant because it makes available to them funds which they can spend as they see developing needs. It permits long-term planning of research programs, frees the researchers from the time-consuming tasks of overfrequent reporting and of preparing new project applications, and makes it possible to attract better qualified personnel because longer tenure can be guaranteed. It also provides funds which can be allocated by the colleges to young scientists who have not yet attained sufficient stature to apply directly for research funds.
>
> The fact that the National Science Foundation is beginning a block grant program this year and that the National Institutes of Health have sought and received authority to give block grants to medical and dental schools gives testimony that there is a trend toward this type of grant program. The need is for the social sciences to have available the same type of grant program. This will require some special legislative action if it is to be achieved.

University centers for research on aging.—One of the essential needs that would be served by block grants should be the establishment of a series of regionally distributed centers and institutes for interdisciplinary research on aging. The need for such centers appeared prominently and repeatedly in the questionnaire responses, in the seminar deliberations, and in the research and training sections of the White House Conference on Aging.

The five centers now being supported with NIH funds are providing useful experience in the development of organization and procedures for research. The present centers are demonstrating that—given the necessary encouragement and support—highly qualified scientists from various disciplines will turn their attention and energies to research on aging and that, when indicated by the nature of the problem, they will coordinate their work on a multidisciplinary basis. Slowly but unmistakably, young specialists in gerontology are beginning to appear.

One major deficiency, now causing a rising amount of concern, is the lack of such centers within the field of social science or social gerontology. The NIH-supported centers are, as noted earlier, almost completely focused on biological and medical research. Considera-

tion should be given to providing support for at least one institute of social gerontology within each major region of the country. Many of the social, economic, and other problems of aging vary with local conditions and must be studied by researchers who are close at hand.

The effective encouragement of university research and teaching centers on behalf of the problems of the aged would, in addition to providing research facilities, serve as training centers for research specialists and technicians and would afford an opportunity for graduate students to undertake work in the field of gerontology.

Career investigators.—The establishment of positions for career investigatorships in gerontology at both the aging centers and within university departments would provide the means of drawing some of the highest qualified people into the field on a permanent basis. Typical of the proposals made on behalf of these positions were recommendations that "gerontological positions" be established for professors and associate professors. One of the recommendations noted that the—

> immediate establishment of 6 to 10 of these appointments across the Nation would lift the whole field of medicobiological investigation of gerontology to a new level at one swoop.[35]

Scholarships and fellowships.—Many of the experts replying to the subcommittee questionnaire emphasized that an adequate supply of researchers will not materialize until scholarships and fellowships are established in the field of gerontology. The participants in the seminars discussed the means of overcoming the deficit of trained researchers. They came to the conclusion that what is involved is an immediate and continuing process of recruitment designed to attract senior researchers and at the same time draw younger people into the field.

Financial aid to the graduate students combined with an opportunity to work with senior men will serve this purpose. With the establishment of research centers and career investigatorships, students will be encouraged to commit themselves to gerontology with some expectation that they will be able to earn a living in the field.

In conclusion, it should be noticed that too often research in aging has been the byproduct and not the main line of research efforts. This factor was frequently mentioned by the seminar panelists and by the experts replying to the questionnaire. The availability of long-term funds is essential to establishing gerontology as a field in its own right.

Policy research, basis for sound expenditures

"Two kinds of research are needed if we are to find solutions to the problems of aging that are already weighing so heavily upon us and upon our economy," according to the subcommittee's report.

> One is basic research in the biological and social sciences that will lead to a fundamental understanding of the processes of aging and of the numerous problems facing older people, their families, their communities, and society as a whole.
>
> There is an equally urgent need for detailed statistical and

[35] Dr. Geoffrey H. Bourne, Emory University, Atlanta, Ga.

evaluative studies necessary to the formulation of policies and the determination of wise expenditures of public funds. Thus, in considering such major questions as medical care for the aged, it is essential to have complete and reliable information on the number and health status of older people, their incomes, and their insurance coverage as well as on the number and kinds of professional personnel available and the variety and capacity of existing medical care facilities. Such data are now becoming available through such agencies as the Bureau of the Census and the National Health Survey. These and similar sources of basic information must be extended and their data widely disseminated if policies are to be decided on the basis of facts rather than guesses.

A related type of policy research is that of evaluating the assumptions on which policy may be based. Thus, in considering Federal grants for the construction of geriatric hospitals, careful evaluative research must be undertaken to determine whether geriatric hospitals are useful in the first place.

Housing is another field in which there is an appalling lack of knowledge. Testimony accumulated by the committee in its hearings reveals a rapidly rising recognition that hundreds of thousands of older people require housing especially located, designed, and priced because of their health conditions, their low incomes, and their needs for opportunity to mingle with other people and participate easily in community life. Private builders, nonprofit religious, labor, and other groups, and communities are showing increased interest in building housing to meet these special needs. The Housing and Home Finance Agency and the Department of Agriculture have several programs designed to provide financial incentives to these individuals and agencies. Progress in housing for senior citizens is slow but it is underway, as reported in chapter III.

One of the greatest lacks is that of valid and reliable knowledge about what constitutes good housing for older people. Where in the community should it be located? Should there be separate apartment houses and clusters of row houses or individual homes for older people? Should there be common dining rooms in apartment houses? Is there need for health centers and recreation facilities? How can housing be designed to encourage the formation of neighborhood groups and new friendships so desperately needed by older people? What methods of financing can be devised to bring good housing within the reach of the thousands upon thousands of older family units that cannot pay an economic rent?

Answers to these and scores of other questions are needed for the guidance of architects, community planners, builders, and public and private agencies. Yet, this is a field of both basic and policy research which has been almost totally ignored by both research workers and fund granting agencies. It is a field in which the committee believes research should be pushed as rapidly as it is possible to do. Housing is built to last 40, 50, or more years. Certainly, questions of design, location, inclusion or exclusion of related facilities, and mat-

ters of financial policies and terms should be based upon the best possible knowledge that can be obtained.

Funds should be made available to the Housing and Home Finance Agency for research in housing for older people. The committee believes that the Agency should have a continuing demonstration and research program as a means of accumulating information which is needed to guide development of its policies with reference to support of senior citizen housing. And the committee believes, further, that HHFA should have funds with which it can contract for more basic studies of the housing circumstances and needs of older people and of their preferences for and reactions to the different kinds of housing that are being and can be made available.

The problems identified above are within the area of policy research. The committee, as members of a legislative body concerned with the problems of more than 17 million senior citizens, feels that this area of objective data collection and program evaluation is one requiring immediate emphasis.

This type of research was well defined by one of the subcommittee respondents:

> * * * Policy research refers to the pattern and principles of functioning which are or can be followed by local, State, Federal, or private agencies in meeting their obligations to the aged. It is possible that policy research is similar to so-called evaluation research, in which the effort is devoted to evaluating the success or failure of a program to achieve a stated objective.[36]

In response to the subcommittee's questionnaire Prof. Wilbur J. Cohen, of the University of Michigan, now Assistant Secretary of the Department of Health, Education, and Welfare, suggested questions for policy research in the economic and social welfare field:

> Should the retirement age be increased or lowered? What factors should be given weight in this area?
>
> Should the "retirement test" in OASDI be repealed, modified, or retained? What would be the impact on individuals and the economy?
>
> Is the test of total disability in terms of "inability to engage in any substantial gainful activity" satisfactory or unsatisfactory for older persons? Would an "occupational" test be more satisfactory?
>
> What is an "adequate" income for the aged? What is an "inadequate" income? What is the relationship of these levels to the level of the gross national output?
>
> What changes in tax policy are needed for the aged? How can these be evaluated in terms of the needs of other age groups?

Participants in the seminars also pointed to the need for policy research on such questions as—

> How would specified types of technological change affect employment opportunities and policies for older persons?

[36] Dr. Ewald W. Busse, director, Center for the Study of Aging, Duke University, Durham, N.C.

In terms of the health needs of older people, urban transportation requirements and their social and recreational needs, what are the factors involved in providing "adequate" housing for the elderly?

What are the psychological aspects of aging that have pertinence in relationship to the older person's ability to work, to live independently, and to achieve satisfactory relationships with other people?

Policy research is moreover essential not only in determining the role of Government in meeting the needs of the aged, it is concerned with the broader scope of these problems within the entire socio-economic-political complex in which the problems are found. A sociologist, in discussing family relationships of older people, commented that under "the impact of industrialization and urbanization the three-generation family has disintegrated as a household and as a unit of economic production." [37] The implications for policy research are clear.

It would appear to the committee that research on policy questions affecting our older citizens should long since have been accepted as a Federal responsibility. It has not been so accepted, except for token efforts. It must be accepted promptly, and fully, if we are to avoid the serious consequences that would be entailed by ill-considered or ill-informed actions directly or indirectly affecting the status of the aging in our society.

Federal expenditures for research on aging

The Nation has given repeated and increasing recognition to the fact that the problems of the aging and aged are national problems calling for Federal action and the utilization of national resources. Evidence of this conviction on the part of the Congress is found in the enactment of the Social Security Act almost 30 years ago, in the establishment of the several national health institutes for research on chronic disease, and, more recently, in special provisions for the aged in housing legislation, construction of geriatric medical facilities, and support of community health and social services aimed to enable older people to continue to live independently in their own dwelling units. The Congress has obligated itself, therefore, to defray the costs of research which will insure properly directed and efficient use of the funds appropriated for these and other programs.

Total Federal expenditures for research on aging for fiscal year 1962 amounted to about $40.6 million. Eighty percent of these expenditures were made by and through the National Institutes of Health: the remainder by the Veterans Administration, the Public Health Service, the Social Security Administration, the Food and Drug Administration, the Department of Agriculture, and other departments and agencies.

It is revealing of the current situation to note the amount and distribution of research and training grants made by the National Institutes of Health. These are shown in the tables presented herewith.

[37] Ernest W. Burgess, "Family Structure and Relationships," Aging in Western Societies, University of Chicago: University of Chicago Press, 1960, p. 297.

National Institutes of Health research and training grants in aging, active as of Jan. 31, 1962

Institute	Primarily related to aging		Secondarily related to aging	
	Number	Amount	Number	Amount
General	56	$1,872,931	79	$3,252,382
National Cancer Institute	13	396,893	48	1,144,473
National Heart Institute	71	2,562,590	172	10,497,318
National Institute of Allergy and Infectious Diseases	13	195,672	39	567,336
National Institute of Arthritis and Metabolic Diseases	65	1,272,351	88	1,808,850
National Institute of Dental Research	19	240,529	30	561,155
National Institute of Mental Health	37	1,409,513	39	1,950,972
National Institute of Neurological Diseases and Blindness	32	507,019	78	2,123,578
Total	306	8,457,498	573	21,906,064

Of the grants related to aging in active status in January 1962, only 306, or just over one-third, were primarily for research in aging. In the remaining two-thirds of the grant-supported projects, aging was of only secondary interest to the investigators. It may be noted, also, that the great majority of the grants were for research on disease processes and biological aspects of aging. Funds allotted for research and training in the social and psychological aspects of aging were alarmingly small.

The following table brings some of the above data up to date as of December 31, 1962:

NIH research and training grants primarily related to aging, active as of Dec. 31, 1962

Institute	Number	Fiscal year 1961	Fiscal year 1962	Fiscal year 1963	Total
General [1]	67	$27,197	$1,361,385	$1,179,570	$2,568,152
National Cancer Institute	13	----------	268,506	188,583	457,089
National Heart Institute	72	296,195	950,497	2,276,091	3,522,783
National Institute of Allergy and Infectious Diseases	18	----------	103,387	180,254	283,641
National Institute of Arthritis and Metabolic Diseases	68	----------	411,724	860,483	1,272,207
National Institute of Dental Research	17	----------	171,979	35,308	207,287
National Institute of Mental Health	45	35,057	679,002	671,458	1,385,517
National Institute of Neurological Diseases and Blindness	39	----------	303,941	438,367	742,308
Total	339	358,449	4,250,421	5,830,114	10,438,984

[1] Division of General Medical Sciences.

NOTE.—The overall annual dollar volume of research and training grants ("Total" column) essentially reflects the latest calendar year activity while the fiscal year columns indicate the latest appropriation year from which funds were derived to support these projects.

It is of even greater concern to examine aggregate expenditures for research in relation to all federally administered funds for support and services for older people. Estimated total expenditures for all major programs for older people in fiscal year 1962 were as follows: [38]

Income maintenance	$19,832,000,000
Health and medical care	890,000,000
Housing	132,000,000
Employment	43,000,000
Other	22,000,000
Total	20,191,000,000

[38] Federal Council on Aging, "How the Government Works for Older People," Washington: U.S. Government Printing Office, 1962, p. 104.

Compared with this total of more than $20 billion in total expenditures, research represented two-tenths of 1 percent. The gross inadequacy of Federal expenditures for research on aging becomes apparent when it is known that the ratio of all research expenditures to all Federal expenditures for all purposes is 10 times as large, or 2 percent of the total.[39]

It was reported at the beginning of the chapter that research has paid huge dividends in the extension of life. Similar results can be anticipated in the areas of human behavior and in the solution of social problems. In the field of mental health a national Governors' conference in 1954 recommended that 10 percent of a State's mental health budget should be devoted to research and training. This proportion has become an achievable standard in many States and has been a major factor in the reduction of State mental hospital populations during recent years. It is important also to bear in mind that the special problems of conducting research in this area require a complex methodology unique in the field of research and correspondingly more costly. As one authority has put it:

> What seems to be clear is that the field of aging presents particular difficulties which operate to increase the cost of research. At younger ages when children and youth are in school or university, numbers of persons are readily available. But the student of aging has to go out and secure his subjects either through the cooperation of industries and social agencies or by house-to-house canvass. * * * generally speaking, the projects now going on involve extensive cooperation over a period of time with many people.[40]

Personnel and facilities available for research on aging are seriously limited as has been pointed out in the preceding pages. There is no point in recommending appropriations for research in aging beyond the capacity of university and other research centers to use them. The committee believes, however, that a reasonable objective for Federal expenditures on research in this field well before the end of the present decade would be approximately 1 percent annually of total funds paid out for Federal programs for the aged.

THE FOCAL POINT FOR RESEARCH AT THE FEDERAL LEVEL

One of the most compelling needs today is for a focal point at the Federal level for research on aging to give critically needed stature, focus, and direction to research in the entire field, and particularly to the underdeveloped areas identified in the preceding pages.

We have become convinced, through our studies, that the National Institutes of Health have been moving forward, both in conducting research on aging within their own agencies and in their research grant activities. These activities should receive continuing encouragement and support. We hope that the new National Institute of

[39] "Action for the Aged and Aging," a report of the Committee on Labor and Public Welfare, U.S. Senate, Rept. 128, 87th Cong., 1st sess.: U.S. Government Printing Office, 1961, p. 98.

[40] John E. Anderson, "Research on Aging," Aging in Western Societies, op. cit., p. 374.

Child Health and Human Development will make research on aging one of its principal focal points of activity.

The committee is gratified, too, with the beginning of support of research on aging by the National Science Foundation, the Department of Agriculture, the Office of Vocational Rehabilitation, the Office of Education, and the Social Security Administration. We are concerned, however, with the wide dispersion of these programs and with the almost total lack of coordination among them. We are concerned that support is still unevenly distributed over the areas of critical research need and that there are significant problems about which nothing is being done to advance knowledge. Moreover, there is, at present, no way in which those who may be interested in doing research can become aware of overall development of the field, of the problems most acutely in need of study, and of potential sources of support.

Our committee is convinced, therefore, that beyond the strengthening of existing mechanisms, there is urgent need to create a single mechanism at the Federal level which would serve (*a*) to keep abreast of the need for knowledge in the several aspects of aging, (*b*) to demonstrate to universities, foundations, voluntary organizations, and the public, the importance of these problems to the Nation, and (*c*) to properly guide the distribution of funds for the various types of gerontological research which are now almost totally neglected.

The subcommittee, in its 1961 report, identified the following characteristics for the Government mechanism suggested:

(1) It should be so located, so financed, and so directed as to command the same prestige as do our excellent National Institutes of Health.

(2) Like the existing National Institutes, it should conduct research on its own, particularly as regards what we have described as policy research, but the greater part of the funds allocated to it should be spent in the form of research and training grants—with emphasis on block grants—to universities and other public nonprofit organizations willing to undertake meaningful research, training programs, and demonstrations in the field of gerontology.

(3) Like the existing National Institutes, it should have a council to consider and pass on all contemplated grants and research projects. The council should be composed of outstanding social scientists and laymen, all of whom have demonstrated interest in, and knowledge of, the problems created by the aging process and it should have, as ex officio members, representatives of other Federal agencies concerned with aging.

(4) Its research program—both its own and that of its grantees—should emphasize the interdisciplinary approach and give particular attention to the social sciences.

(5) It should establish and maintain a scientific environment of high order both intramurally and with respect to its outside grants for research and training.

To serve as the Government mechanism, the subcommittee suggested a National Institute of Gerontology, saying:

> It is therefore our recommendation that the Congress promptly establish a National Institute of Gerontology with sufficient funds and staff to give the national leadership and recognition which research in the field of aging requires and deserves. The establishment of this Institute should in no way reduce the obligation of existing institutes to support those areas of aging within their immediate scientific interests. Rather it should add to the total national investment in promoting the health, welfare, and productive ability of an increasingly aging population.

Opposition to the recommendation for a National Institute of Gerontology was expressed by Senator Dirksen in a minority report which read in part:

> I am opposed to the recommendations contained in the majority report proposing the establishment of a National Institute of Gerontology and Federal grants to the States for the construction of multipurpose senior citizen centers.
>
> The stated purpose of the proposed National Institute of Gerontology would be to encourage and promote the development of a soundly based research in the field of aging. Although the majority's recommendation does not so state, it is apparently their intention to establish this proposed Institute within the existing National Institutes of Health.
>
> The National Institutes of Health is composed of Institutes engaged in research in the following fields: arthritis and metabolic diseases, cancer, dental, heart, mental health, allergy and infectious diseases, and neurological diseases and blindness. Many of the research programs now being conducted by these Institutes are directed specifically to those aspects of diseases commonly associated with old age. The establishment of a statutory Institute, as proposed by the majority to conduct research in gerontology would not be devoted solely to research in the medical sciences but would also authorize the employment of scientists from the physical and social sciences to conduct research programs in these fields as well.
>
> Because of the broad scope of authority which would be granted to the proposed Institute, serious problems would arise in attempting to avoid duplication of research and other activities now being carried on by the existing institutes. It is difficult indeed to envision a harmonious relationship developing between the existing institutes, which are based upon specialized fields of medicine and one which is concerned with, inter alia, the physical and social scientific study of the phenomena of old age.
>
> In view of the fact that age-related research programs are presently being conducted by the several institutes of health, there appears to be no clear and manifest need for an Insti-

tute of Gerontology as proposed by the majority report. * * *[41]

The 2 years that have elapsed have reinforced our conviction that there is need at the Federal level for a focal point to provide the national leadership and recognition which research in the field of aging requires and deserves. On January 31, 1962, a high-level, independent U.S. Commission on Aging was proposed by this committee's chairman (S. 2779) and by Representative John Fogarty, chairman of the House Subcommittee on Appropriations for the Department of Labor and the Department of Health, Education, and Welfare (H.R. 10014). As chapter V points out in detail, their broad proposals for a Commission devoting full time to the full range of problems and potentialities of our older citizens, has as an essential feature, a program of grants for planning and for demonstration research and training projects.

The Commission would make continuing surveys and studies, collect and disseminate information, develop policy and legislative proposals in the light of these studies, provide technical assistance and conduct research and demonstrations, and sponsor and cooperate in training and research programs.

Here then would seem to be the ideal mechanism to serve as the focal point within the Federal Government for a greatly expanded, vital program of research in the problems and potentials of our older population.

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[41] "Action for the Aged and Aging," Rept. No. 128, 87th Cong., 1st sess., minority views of Senator Dirksen, p. 128.

CHAPTER V. EFFECTIVE ORGANIZATION OF FEDERAL PROGRAMS IN AGING

The existence of this special committee and the number of Senators who have contributed through their membership on it is in itself recognition that there is wide and deep concern with the problems of older people throughout the United States. The committee's hearings have borne this out and have well illustrated both the scope and complexity of those problems and the need for effective leadership at the Federal level in devising and promoting solutions to them. Interest in the House of Representatives also has been clearly demonstrated. Yet despite this and despite the oft-expressed concern of the Nation as a whole, the executive branch of our Government, even through changes of administration, has dragged its feet for over a decade and still refuses to create an agency that can give full time and attention to the broad range of interrelated needs and potentials of older people, that can serve as their spokesman, and because of its independence of other agencies and high position in the governmental structure, can command the wholehearted cooperation of all governmental agencies and of nongovernmental organizations in achieving effective and coordinated action. Such an agency, functioning at the White House level, serving as the focal point for Federal activities in aging, capable of coordinating the work of the departments in this field, devoting its full attention to this area, and able to advise the President and the Congress without departmental bias, is imperatively needed.

When spurred by congressional attention, the executive branch has taken action or put forth plans for action only to relapse when the spotlight was off. The measures taken with respect to coordinating, highlighting, and giving drive to a multiplicity of Federal programs in aging have been sporadic, spasmodic, piecemeal, hesitant, and futile.

Responsibility for developing programs to serve the needs of older persons is, of course, a shared responsibility. It involves the Federal Government, the States and their communities, and voluntary agencies and organizations at all levels. This partnership of governmental and voluntary agencies is in accord with our time-tested American tradition; it best takes advantage of the essential contribution the individual himself must make in creating a secure, healthful, and meaningful climate for the later years.

The opportunity to share in this responsibility has caught the imagination of many of the States and scores of communities and organizations over the past decade. The variety of approaches and programs developed is almost infinite, reflecting the many-faceted nature of older people and the older population, the needs perceived by sponsoring agencies, and the knowledge and resources available to them. While these developments have come rapidly and while they reach across the entire country, they are nevertheless spotty, often inadequately conceived, and generally undernourished.

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The experience of the past decade, culminating in the White House Conference on Aging in January 1961, has clearly indicated the need for a focal point within the Federal Government for providing information, guidance, and support to the rapidly growing number of agencies and organizations eager to shoulder part of the responsibility.

Functions to be carried out by such a focal point within the Federal Government have been identified, as follows:

(1) Conduct and support research and keep abreast of emerging knowledge and developments in the total field of aging;

(2) Identify unmet needs and develop policies and program recommendations designed (*a*) to alleviate the problems of aging and (*b*) to enable older people and society to derive the benefits of longer life;

(3) Maintain liaison, develop cooperative relationships, and coordinative mechanisms among Federal agencies, national and international organizations which share responsibility in the field;

(4) Provide technical and financial assistance for organization, research, and demonstrations, and program development to States, communities, universities, and other organizations in areas not covered by existing programs;

(5) Serve as a national clearinghouse for the collection and dissemination of information essential to research, training, legislation, and program development;

(6) Sponsor and cooperate with other agencies in conducting conferences, seminars, training, and research programs in aging;

(7) Compile, and make public, program aids, factbooks, including guides, bibliographies, case studies, exhibits; and

(8) Conduct an intensive followup of the recommendations and actions resulting from the White House Conference on Aging.

Our committee's recent field hearings provided ample evidence of the desire of the States and communities to carry out their vital roles in this partnership. Effective performance of their roles, however, is dependent on effective performance of those functions which are the responsibility of the Federal partner. And our hearings made it clear that we lack anything even approaching effective performance on the part of the Federal partner.

The failure, to date, to properly organize Federal activities in aging, which is unforgivable, is easily understandable. There has been no directive from above. The task has been left up to the coequal agencies involved and no one agency is willing to release a shred of its authority to the others. The Department of Health, Education, and Welfare which feels itself somehow more equal than the other departments with interests in aging, is prolific of ideas which would give it a dominant role but adamant in its opposition to any proposal which might lead to the coordination of its activities in aging with those of other agencies under the leadership of a body above itself and the other agencies. The repeatedly undertaken pretense of resolving such difficulties by bringing together the Secretaries of the various departments in a Federal Council on Aging or a Presidential Council on Aging have been, are, and always will be meaningless. It is absurd to expect that key officials in existing agencies with sufficient authority and prestige to give leadership and continuing support to the effort needed can devote attention to such a task. Quite naturally, but

unfortunately for the aged, they have other weighty and statutory responsibilities which preclude more than occasional and tangential personal involvement in the field of aging.

The reluctance of career staff within the executive branch to support the development of an effective mechanism for overall study, planning, and coordination is understandable in terms of the usual pattern of opposition by established agencies to a new entry in a field they wish to reserve for possible future expansion for themselves, particularly one with such wide public appeal.

It is not as easy to understand why those in the executive branch who have and are responsible for taking a Government-wide view should be content to permit this lack of overall leadership and representation in an area of such dimensions, present and potential. It is almost impossible to understand in view of the fact that people in the administration with such responsibility did so excellent a job last year in persuading the Congress that it was important to establish in the Executive Office of the President an Office of Science and Technology. The reasons they so persuasively advanced at that time apply with equal force to our contention that Federal activities in aging should be similarly centered in an agency at the White House level. That this is so was spelled out in a joint letter to the President from Senator McNamara and Congressman Fogarty[1] which reads as follows:

April 9, 1962.

THE PRESIDENT,
The White House,
Washington, D.C.

DEAR MR. PRESIDENT: We have given careful study to your Reorganization Plan No. 2 of 1962 designed to establish an Office of Science and Technology as a new unit within the Executive Office of the President. In so doing, we have read with great interest the reasons underlying that proposal, both as set forth in your message to the Congress and as given in the study submitted to the Senate's Committee on Government Operations by one of its subcommittees in justification of such a proposal.

We find the reasoning persuasive. We shall support the proposal.

We write today to point out what we believe to be compelling parallels between the reasoning underlying your proposal and that on which our identical bills calling for the creation of a Commission on Aging, similarly responsible to the President, rests.

Referring to the National Science Foundation, your report states that it "being at the same organizational level as other agencies, cannot satisfactorily coordinate Federal science policies or evaluate programs of other agencies. Science policies, transcending agency lines, need to be coordinated and shaped at the level of the Executive Office of the President drawing upon many resources both within and outside of the Government. Similarly, staff efforts at that higher level are required for the evaluation of Government programs in science and technology."

[1] Senator McNamara and Congressman Fogarty introduced identical bills (S. 2779 and H.R. 10014) calling for the creation of a U.S. Commission on Aging. The bill is discussed later in this chapter.

Substitute "Special Staff on Aging" for "National Science Foundation" and "policy with respect to aging" for "science policies," and your reasoning applies perfectly to our proposal.

You advise the Congress that should the Office of Science and Technology be created, "the Foundation will continue to originate policy proposals and recommendations concerning the support of basic research and education in the sciences, and the new Office will look to the Foundation to provide studies and information on which sound national policies in science and technology can be based."

Similarly, should the Commission on Aging be created, the Special Staff on Aging in the Department of Health, Education, and Welfare will continue to or will be stimulated to originate policy proposals and recommendations concerning the support of basic research and education in the field of aging and the new Commission will look to the special staff to provide studies and information which will help provide the basis on which sound national policies aimed at resolving the major problems concerning our more than 17 million older people can be based.

The subcommittee study brought out the fact that some eight departments and agencies, quite understandably and properly, conduct major programs in the sciences and that it is essential to create a high-level agency to coordinate, stimulate, and objectively report on their activities in that area.

Similarly, some five departments and agencies have major contributions to make in the area of aging. This situation calls for the creation of a similar high-level agency for the same reasons and, in addition, because, although the responsibilities of certain of the agencies in the field of aging are of major importance to those concerned with the problems of aging, they are too often given little attention by departmental and agency directors confronted by a host of other responsibilities.

The study states that * * * "a President can be greatly helped by having his own above-the-department science advisers. They can give him counsel 'in the round'—from a Government-wide, rather than departmental, perspective. They can assist him in cross-agency coordination. They can alert him to promising developments lying outside of obvious agency missions and having no departmental home. They can call to his attention programs of high national priority, but low agency priority. They can help him in checking on agency performance."

That is an impressive list of reasons for supporting your proposal. Each of those reasons, we believe, applies with equal cogency and strength to our own proposal.

Finally, the study advises us that, "the President and the Bureau, where major questions are at issue, can profit greatly by having a ready source of above-the-department technical advice. A President needs the protection of more than one channel of technical counsel. Also, departmental experts may beocme overcommitted to their own agency program objectives. Program protagonists are not necessarily good program critics."

Certainly that is as true in the field of aging as it is in the area of science.

We are quite confident that such heads of departments and agencies as may be called to testify on your Reorganization Plan No. 2 will find your reasoning and that of the Senate's study group quite convincing and will support your recommendation. We hope, particularly in view of your own great interest in the problems of the aged, which, we know, antedates your service on the Senate's Subcommittee on the Problems of the Aged and Aging, that these same officials and your administration will find that same reasoning just as convincing when they report on our recommendation.

Faithfully yours,

PAT MCNAMARA,
U.S. Senator.
JOHN E. FOGARTY,
Member of Congress.

Dimensions of the problem.—The bare statistics concerning the growth of our older population in absolute numbers and proportion are by now familiar. The argument can be made that adequate representation at an identifiable point in the executive branch is due a population group whose number exceeds the population of any State; which exceeds the total population now living on farms; which will soon exceed in number the body of organized labor. Each year more people reach age 65 than are in the population of each of several States.

The need for overall leadership by planning and coordination can be supported on a fiscal basis alone: The Federal Council on Aging in its 1962 report to the President estimates over $21.6 billion as the cost of all Federal programs and tax benefits in fiscal year 1962 as compared with $11.6 billion 5 years earlier, and $5.6 billion 10 years ago.

Earlier conclusions of subcommittee.—The report of the Subcommittee on Problems of the Aged and Aging dealt with the subject of Federal organization. It pointed out that despite the intensity of problems and the numbers involved, there was—

> no special agency authorized by the Congress to be concerned full time with the total range of problems in this national area of public policy. The Nation's approach * * * is fragmented, piecemeal, haphazard, and without focus * * *. The position of the programs * * *is relegated to a secondary role and low status * * *.
>
> * * * The single most obvious fact about the problems of aging is that they concern in one way or another practically every department and agency of Government * * * the only efficient approach is an organic overall view.

Legislation proposed.—Developments since then have given further evidence of the truth of this statement. So much so that Senator McNamara, having introduced S. 1359 in the first session authorizing an Assistant Secretary and an Office on Aging in the Department of Health, Education, and Welfare, subsequently introduced S. 2779 in the second session jointly with Representative Fogarty with a provision for an independent Commission on Aging.

Speaking on the new bill, Senator McNamara said:

> Despite similarity of objectives, the organizational approaches of S. 1359 and my new bill are obviously quite different. S. 1359 would strengthen an existing agency; the proposal Congressman Fogarty and I are now making jointly, establishes a new agency.
>
> I am well aware that there is ample evidence that the effectiveness of an agency in determining public policy is directly related to its place in the established departmental structure of Government. Sound judgment would, therefore, dictate against creating a new instrument of Government if one already exists that can do the job that so urgently needs to be done.
>
> I believe, however, that we do not now have such an agency of Government: One that can give full time and attention to the full range of interrelated needs and potentials of older people, serve as their eloquent spokesman, and—because of its independence and high position in the governmental structure—command the wholehearted cooperation of all governmental and nongovernmental agencies in achieving effective action. * * *
>
> The bill I am introducing today, therefore, provides for a high-level independent agency which will devote full time to the total range of needs and potentials of older people, without fragmentation and with balanced perspective, and which will command the respect and full attention of the Nation's total efforts in behalf of the aging.

The bills, S. 2779 and H.R. 10014, introduced by Senator McNamara[1] and Congressman Fogarty call for the establishment of a permanent and independent U.S. Commission on Aging. It would provide a bipartisan, three-man Commission, appointed by the President and responsible to him, to be concerned full time with the full range of problems and potentialities of America's more than 17 million senior citizens. The Commission would serve as the focal point within the Federal Government for developing national policy; for providing information, guidance, and support to governmental and nongovernmental agencies with programs in the field of aging; and for developing and sponsoring a balanced nationwide program to achieve the objectives set forth in its preamble. It would have the advice of an Advisory Council of 20 members, including the heads of departments concerned, three Senators and three Representatives and also of an Interdepartmental Council. The bills would also authorize planning and project grants to assist the States in developing programs to benefit older persons and would provide for Federal sharing in the administrative costs of a State's planning and coordinating agency. Grants to institutions and organizations for demonstration, research, and training in the field of aging are also authorized.

Bases for support of commission form of organization.—We favor a commission as the organizational pattern within the Federal Government because it would lend (1) better and greater status, (2) balance,

[1] With the cosponsorship of Senators Long of Missouri, Randolph, of West Virginia, and Pell, of Rhode Island.

(3) strength, (4) continuity, and (5) visibility to Federal activities in aging. Status and balance, plus a comprehensive view, are both relative to the need to avoid domination of programs in aging by the Department of Health, Education, and Welfare and by the Welfare Administration in that Department—a fear shared by both Federal and State agencies, and with ample reason, as events have demonstrated. A commission can give full time and attention to the total range of interrelated needs and potentials of older people, and because of its independence and high position in the governmental structure, is designed to command the cooperation of all governmental and nongovernmental agencies. It is a principle of public administration and of management generally that you cannot coordinate from below, that specifically departments and independent agencies cannot be coordinated by a subordinate unit within one of them. All efforts over the years to prove the contrary have been futile, except insofar as they have served as tests to prove clearly that it cannot be done.

A balanced approach, a comprehensive view cannot be attained from a niche in the structure of one department. Institutional loyalties, and priorities, prestige, the system of rewards and punishments all combine to press into conformity with traditional patterns and goals, even broad-gauged, dedicated individuals. This process takes place even with Cabinet officers in relation to their departmental responsibilities. Their subordinates are much less able to maintain a total governmental view of all the programs, present and potential, affecting older persons.

The strength of the commission derives from the authorities and facilities including the grant provisions, in the proposed legislation, and especially from its relationship to the President. The main argument advanced by opponents of a commission has been that the President should not be burdened by another unit attached to his office, and that if it were, the commission would not in fact have opportunities to consult with the President. The position of proponents of a commission is not based on any expectation of frequent contacts with the President or his chief aides. In fact, the burdens on the Executive Office would be lessened with the creation of a commission. If the commission has the authority to go directly to the President, it will rarely, if ever, need to exercise this privilege to settle a difference within the executive branch. The commission itself would be preferred by departments and agencies as the level at which to reconcile differences and to reach agreement. Even though the commission would have no authority over Cabinet members and heads of agencies, its advice and recommendations would have considerable weight with these officials, in view of its facilities for study and consultation, including the interdepartmental committee and the public advisory board. If on the basis of such deliberations, the commission consisting of three Presidential appointees unanimously or by a majority favored a proposal for action, policy, or point of view, obviously the head of any agency would be strongly influenced, but still could act as he saw fit in his own sphere of responsibility.

The commission structure will have continuity through legislative authorization, Presidential appointment, and the fact that there will be three members. Being independent of any department, it will not be subject to the changes in organization and personnel which have characterized the Department of Health, Education, and Welfare.

One witness, referring to the Special Staff on Aging, remarked at the hearings in 1962: "I have actually seen five different staff directors under four different Secretaries."

Presidential appointees are less likely to be moved about, and if one should resign, two remain to provide continuity, at the President's pleasure.

High visibility and a favorable image of the Federal Government's concern with the needs and potentials will be provided by a commission responsible to and appointed by the President with the advice and consent of the Senate. This is more than ever needed now that the Special Staff on Aging has been removed from the Office of the Secretary and downgraded to a place in a new Welfare Administration which is primarily identified with the agency responsible for public assistance.

At least one witness foresaw this development:

> My experience and that of most other States argues against placing responsibility for programs for older persons within an operating department * * * From what I know of the operation of the Department of Health, Education, and Welfare, I have tried to envision what might happen if the responsibilities and grant programs were placed in that Department. To get real emphasis, such a program would have to be in the Office of the Secretary, and since apparently operating programs are not usually in the Office of the Secretary, it would probably not be left there. * * *

Another witness questioning the wisdom of assigning coordinating responsibility for aging in a few State welfare departments, said:

> * * * This connotes to the public, and to older people particularly, that we think of them only, or primarily, in the welfare context. Most older people had a "bellyful" of public welfare during the great depression. They will not, in my experience and judgment, use services, extended under welfare auspices, nearly as extensively as they will use them under other auspices.

It was the announced intention of the Department on establishing the Welfare Administration to broaden the concept of welfare beyond the public identification with relief recipients and investigators. However, it is to be expected that more of the color of the major agency in this new organization—the former Bureau of Public Assistance—will rub off on the Special Staff on Aging than vice versa. In any case, this committee is convinced that the Federal Government's voice on aging activities and its major source of guidance in developing policy with respect to aging should not and must not be identified with "welfare" operations. We can well imagine the violent reaction that would occur among America's farmers if our farm programs were directed by a "welfare" agency or among our industrial workers if the Labor Department's programs were put under "welfare." Our older people are equally proud and independent and desire, more than anything else to remain free of and untouched by anything that smacks of "welfare." Yet the Department of Health, Education, and Welfare has seen fit to relegate what was supposed to be the Secretary's Special Staff on Aging, reviewing and advising on all departmental activities in the field, to the Welfare Administration. We believe the Welfare

Administration should have a special staff on aging. So too the Public Health Service and the Office of Education. Labor has one and Agriculture has one. But no one of these, presumably coequal groups in their own sphere, can speak for all: most certainly they cannot coordinate the activities of all. Nor can any one of them meaningfully service a group of Cabinet level officers giving a once a year or once in 2 years nod to the direction of the aging, whether the group bear the title, "Federal Council on Aging" or the more resounding name, "the President's Council on Aging."

Incidentally, the committee notes, with sadness but no surprise, that the renamed President's Council on Aging, announced with great fanfare just when a House subcommittee was considering action on the bill for a U.S. Commission on Aging, has met but once. Its executive committee, of lesser employees, has made no recommendations to the Council. Because Health, Education, and Welfare acquired a new Secretary, it was for months unable to move on its budget. It has a total staff of three professionals and two nonprofessionals responsible in many ways to but one of the many agencies involved. And since HEW, without specific congressional authorization, provides 50 percent of its budget, the Council could not in any case function with the supradepartmental detachment and objectivity that is essential.

Testimony on Federal organizations for aging.—The General Subcommittee on Education, chaired by Representative Cleveland Bailey, held a series of hearings on H.R. 10014 (the Fogarty-McNamara bill). By April 17, when the hearings were held in Washington, it had become clear—particularly as a result of addresses by Assistant Secretary Wilbur Cohen and Representative Fogarty—that the major point at issue was whether we needed a commission or whether the continued vesting of authority in Health, Education, and Welfare and a so-called Council on Aging would do. During the hearings on April 17, 18, and 19 in Washington, 14 witnesses placed themselves on record regarding their position on the commission form of organization provided in the Fogarty-McNamara bill as compared to other forms of organization. It is significant that 13 out of 14 witnessses clearly favored the commission form. This position was maintained in the face of searching questions by members of the subcommittee.

Expert witnesses.—It is interesting to note the backgrounds and affiliations of these witnesses. They came from local, State, and National organizations on aging; they included unions, voluntary and professional organizations, religious organizations. Most impressive in establishing the expert qualifications of the witnesses were these facts: Five were chairmen or executives of State commissions or agencies on aging; five were former Federal officers who had key responsibilities in governmental programs for aging during this decade and were presently occupied in vital nongovernmental posts in the field of aging; one had both Federal and State Government aging posts. Their titles in their former Federal posts included Director of the Special Staff on Aging; Staff Director of the White House Conference on Aging; Special Assistant for Aging in the Department of Labor; Technical Director for Education, White House Conference on Aging; Assistant to the Under Secretary of Health, Education, and Welfare; Chief, Office of Aging and National Office of Vital Statistics in the Public Health Service. All agreed on the frustrations of their experience in attempting to work effectively within the organizational

structure which various administrations had provided in the field of aging. These men, who know Government intimately, felt strongly that an agency over and above those in existing departments was imperatively needed.[2]

The organizational affiliations of the witnesses ranged from the National Conference of Catholic Charities to the National Council of Negro Women and included two large unions which have retired workers' departments—the United Automobile Workers and the United Steelworkers.

It is perhaps of interest to consider the proposal for a U.S. Commission in light of the testimony of Garson Meyer, president of the National Council on the Aging, at the hearing of the Bailey subcommittee in Washington, D.C. Mr. Meyer's testimony was directed to principles rather than to a specific form of organization. Specifically, he said:

> The council would therefore urge that whatever form the Congress may devise to carry out Federal responsibilities in the field of aging, it will recognize not only the responsibilities but the limitations of government, and establish as a basic principle of its operations at all levels cooperation with and effective use of the organized, voluntary services now operating and available to older people at National, State, and local levels.

One of the principles expressed by Mr. Meyer is:

> It is the council's belief that the economic, social, educational, health, and spiritual needs of older people are so inextricably interwoven that to deal with them singly is to present a fragmented and unrealistic approach.

This, incidentally, is the very principle that led to the establishment of the Senate's Special Committee on Aging. It is also the reason Senator McNamara and Representative Fogarty have proposed an independent commission, rather than an organization located in a single department which—no matter how broad its functions—cannot assure balanced representation of all concerned. It is the reason the Fogarty-McNamara bill provides planning grants for the development of an overall State plan, and specifies that all the appropriate public and voluntary agencies must be involved in the development of this plan.

Mr. Meyer's second principle concerned the importance of voluntary effort "working in close cooperation with government"—a close partnership between voluntary agencies and governmental agencies at all levels. Again the specific provision of the McNamara-Fogarty bill for participation of the voluntary agencies in the development of the State plan as well as in the project grants reflects an appreciation of the need for nourishing and strengthening this partnership.

He also urged that grants for experimentation, demonstration and research be determined by priority of the need for new information. Pointing to some of the programs that have already been demonstrated to a rather remarkable degree, he stressed the need for an effective means of disseminating knowledge now available and for providing the machinery to establish these services "in all communi-

[2] Hearings, General Subcommittee on Education, Committee on Education and Labor, House of Representatives, on H.R. 10014, pts. 1 and 2, 1962, Washington, D.C.

ties in some proportion to the developing need." The McNamara-Fogarty bill charges the Commission with responsibility for broadly disseminating information about the needs of older persons and about programs and approaches which meet these needs. Communities and public and voluntary agencies within each State would be guaranteed funds, in proportion to the State's older population, for projects they deem necessary and desirable, with emphasis on the development of action programs and services. Provision is made for the involvement and participation of the voluntary and public agencies of all States and communities in such a way as to promote continuance and further development.

Because funds for aging activities would be broadly defined and widely available—rather than concentrated on the demonstration and training projects of the more sophisticated communities and universities, our growing knowledge can be translated into effective action and services that reach older people in all communities throughout the country.

Most expert of all witnesses was Congressman Fogarty, the sponsor of the bill, who, as chairman of the Subcommittee on Appropriations for the Department of Health, Education, and Welfare, has been examining matching activities in aging for 15 years. Congressman Fogarty, who lent yeoman support to the Department's occasional efforts to coordinate and make meaningful its various activities in aging and those of other departments, is convinced that the job cannot be done from within that or any multipurpose agency. He is convinced that only through the creation of a U.S. Commission on Aging, attached to the Presidency, can the task be accomplished. We are persuaded by his experience which parallels our reasoning. We agree. We urge the prompt enactment of legislation to establish the U.S. Commission on Aging in the form and with the powers set forth in S. 2779 and H.R. 10014 of the 87th Congress.

The counterproposal.—At the insistence of the Bailey subcommittee, a month after the conclusion of the previously scheduled hearings, Assistant Secretary Cohen testified for the Department of Health, Education, and Welfare. At that time, the Assistant Secretary discussed an administration bill subsequently introduced by Senator McNamara ("by request" and "without enthusiasm") and by Representative Bailey (H.R. 11752) and announced that the Federal Council on Aging was being converted by Executive order into the President's Council on Aging with greater stature and fiscal support.

This proposal authorizes $10 million a year for a 5-year program of special project grants to be administered by the Secretary of Health, Education, and Welfare. The objective of this proposal is twofold:

(1) To support research, demonstration, and evaluation projects to deal with some of the many problems faced by our older people.

(2) To encourage and assist universities, professional schools, and other appropriate institutions, organizations, and agencies to step up their training programs for professional and technical personnel needed to provide the broad range of services required by older people.

A major difference between this proposal and that of the McNamara-Fogarty bill—leaving aside the very basic difference in the administer-

ing agency—is that the Department's proposal does not provide for Federal financial participation in the establishment and improvement of State agencies to plan and develop statewide programs. There is no provision for an overall State plan developed through consultation with all appropriate public and voluntary agencies, nor are the State's given any function under the legislation. Nor does the Department's proposal specify how the total of $10 million a year shall be divided between training and research projects or between universities and public agencies serving the aged.

Because the administration's proposal was limited to research and training grants, it is of interest to compare these provisions with the grants provided by the McNamara-Fogarty bill.

Under the McNamara-Fogarty bill, communities and public and nonprofit agencies within each State are guaranteed funds in proportion to their older population, for projects they deem necessary and desirable with emphasis on development of action programs and services. Initial approval of grants is made within the State and any applicant may have a hearing before the State commission. Funds are also provided for planning and administration. These are in addition to the project grants and make the project grants more meaningful and feasible to the State and its communities: first, because these projects will fit into an overall plan developed on the basis of consultation with all appropriate public and private agencies; secondly, because the States are enabled to furnish expert assistance in the planning of research and demonstration and in the preparation of applications which have a real chance of approval. This procedure would be quite similar to that followed under the time-tested and highly successful Hill-Burton hospital planning and construction program. Adoption of this same procedure acts to prevent a small clique in Washington from deciding what is good for the States and which groups or communities shall get grant assistance. Grants can be finally approved in Washington, but only upon a determination by a State that the grant application fits into the State's coordinated plan and has the approval of the State.

Under the departmental sponsored bill, the typical community agency would be in grossly unequal competition with university-sponsored applications since universities have had long experience in the preparation of research proposals; their faculties earn much of their prestige and promotions through their ability to secure research funds. Under these circumstances, projects would be less oriented to action and services; they would have no necessary relationship toward the needs and objectives as the State or communities see these and would not be part of a plan; there would be no assurance that a State would secure any funds and the extent to which funds might be available would be completely subject to decision by a Washington staff. Under the McNamara-Fogarty bill, the Federal administering agency can exercise such absolute power of decision only under title IV authorizing $2 million for special demonstration, research or training projects, but about $13 million of the authorization for planning, administration, research, and demonstration projects would be allocated among the States and expended in accordance with the plans of each State. The McNamara-Fogarty bill provides for involvement and participation by States and communities in such a way as to promote

continuance and further development. The departmental bill might be a great boon to certain specially favored universities, but their researches would be less likely to result in continuing services to the elderly.

Subsequent developments.—The administration bill (H.R. 11752) apparently gained no support. Subsequently Representative O'Hara introduced H.R. 12799 to provide formula grants to the States rather than grants to nonprofit organizations. This bill was said to have had some administration support as a substitute for its first bill. In essence, therefore, it may be inferred that the Department was prepared to accept the grant provisions of the McNamara-Fogarty bill, but not the commission form of organization.

A followup by the staff of the Special Committee on Aging with respect to the effects of resurrecting the Federal Council as the President's Council revealed that one or two additional staff members had been hired, that the members of the Council had not met and that there were no activities to report. An executive committee, of increasingly lower status, has met from time to time, but no recommendations for action have been forthcoming. To all appearances, the Council on Aging is inactive, even comatose, at the present time. Whether the future will see efforts to revive it again or not, the forecasts of futility expressed by the expert witnesses have been borne out by subsequent events.

In December of 1962, the Secretary of Health, Education, and Welfare announced the establishment of a Welfare Administration in the Department of which the Special Staff on Aging will be a part. Whether the President's Council, which has been functioning to all intents and purposes as a division subordinate to the special staff, is part of this relocation is not clear. Presumably the Council which was allegedly upgraded in May, was clearly downgraded in December. Apparently the question "Do you love the aged in December as you did in May?" has been answered in the negative. In any case, except for a brief period at the beginning of its existence, this mechanism for overall coordination has not been viable.

Tapping our human resources.—Our hearings made clear the fact that there are hundreds of thousands of our older people who are able and willing—in fact, anxious—to make their contributions as senior citizens of the community, receiving in return the satisfaction of knowing that they are still useful, valued members of society.

Today there are perhaps as many as 14 million people over 65 who are fully retired. In the next 40 years this number may double. The average retired person has about 80 hours a week of free time, many of them hours which hang heavy on his hands. Literally billions of man-hours are thus available which could be channeled into creative activity, for the good of the individual and of society in general. We believe that our older people are more than ready to pick up this challenge but that, as a society, we are not making it easy for them.

We cannot reasonably expect our older people to lead full and satisfying lives and to make their potential contribution to society if they do not have adequate food, clothing, shelter, and medical care—or even if they are preoccupied with worry about meeting the bills for these essentials.

A person who is economically disadvantaged is also socially disadvantaged and likely to have especially acute health problems. Various studies have shown a high correlation between isolation and mental illness or—the other side of the coin—between participation in meaningful activities and physical and mental health.

Of the older people who are relatively free of economic worries many are much more interested in volunteer activities than in full-time employment. The Senior Citizens Association of Los Angeles County, Inc., for example, made a survey of its membership "to learn the views of the senior citizen himself. Too often we have had to sit in the audience while other age groups tried to tell us how we should spend the remaining years of our lives." Of their members classified as in "the somewhat higher income group" and of whom half reported having incomes adequate for their needs, 28 percent answered "yes" to the question "Are you interested in volunteer work?" Of the same group, only 7 percent said they would like a full-time job and only 25 percent a part-time job.

The readiness of this association's membership to serve was conveyed to our committee in the following statement:

> If one is to believe all the statements that you read and hear about persons retiring at 65 years of age you would come to the conclusion that such an individual is through with all life's activities and is of no more use to his community or his nation except to amuse himself with the playing of cards or shuffleboard. The senior citizen often has personal characteristics that are lacking in other age groups, such as patience, tolerance, kindness, and consideration of others. Surely these attributes are of some use to the Nation and to the community.
>
> Seemingly, the general impression of other age groups is that when an older person retires from a wage-paying job he must be considered a burden and a responsibility to his country for the rest of his life. In his early years the senior citizen had the responsibility of making a living for his family, therefore had very little time to devote to service of his community; and now when he does have spare time for community service, he is told that he should spend his time fishing and playing cards.
>
> The Senior Citizens Association of Los Angeles County believes that our government, on all levels, Federal, State, and local, should seek out ways to use this source of human power that is contained in a growing population of older people. They further believe that if older people enjoy reasonably good health, with a decent economic existence, we can in time of disaster or any major trouble in our Nation be an extra source of power for the Nation to draw on. On the other hand, an older group of citizens in poor health and forced to live on a low economic level would just be an added burden in a time of national peril.
>
> The pronouncement of our President in saying that we should think of what we can do for our country is taken seriously by our senior citizens, and we want to be in condi-

tion, both mentally and physically, to serve our country in whatever way we can be used.

During our hearings, numerous references were made to ways in which older individuals are now serving their communities. The more typical of these—although perhaps even these are not widespread enough to be called typical—are: Participating in homemaker services; assisting in united fund drives; helping with community studies; making toys for needy children; rolling bandages; working with the Red Cross and with State and local hospital and clinics.

The committee would like to make known several other kinds of volunteer services which were mentioned at our field hearings and which may not be widely known in other communities. One of these is a service for the blind or other handicapped persons—taking them to the doctors, helping them to get out for some recreation and to church or to visit friends. Another is helping with the distribution of surplus foods through a "good neighbor program." And still another—and this was put forward as a proposal and may not actually be in effect anywhere—was a clothes repair and maintenance unit as part of an activity center. The senior citizen who made this proposal stressed the value that older people place on neatness but pointed out that many of them—and especially the men who live alone—have neither the facilities nor the skills to keep their meager wardrobes in good repair.

We would call attention again to the recommendation of the subcommittee in its last report for a Senior Citizens Service Corps, with Federal grants to help support the local training programs. A bill to implement this proposal had been introduced by Senators McNamara, Randolph, and Clark and 11 colleagues.

> The Senior Citizens Service training program would establish training and refresher programs for developing within the group of willing and able retired Americans the necessary skills for meeting such shortages. Primarily part-time jobs would be filled through such effort.

The committee's 1961 hearings have added immeasurably to the already impressive evidence of the need to provide opportunities for our retired population to engage in useful and meaningful activities while at the same time helping to overcome critical manpower shortages in the vital fields of health, education, and welfare.

The McNamara-Fogarty proposal for a U.S. commission gives specific recognition to the need for channels whereby older people can offer their valuable service. The project grants, for example, would be available for the training of special personnel, including volunteers, who may be needed to carry out the programs and activities. The provision authorizing support for senior centers would specifically include centers that assist older persons in providing volunteer community or civic services.

CHAPTER VI. FEDERAL LEGISLATION AND THE AGED, 1959–63

That there has been a great burgeoning of interest on the part of the Congress in the plight of the elderly during these 4 years is attested to by the growing amount and variety of legislation, designed to help cope with their problems, enacted and considered by House and Senate during this period. We present, herewith, a list of public laws directly affecting the aged or aging which were enacted from 1959 through 1962 and a survey of additional legislation affecting the elderly which was pending at the close of the 87th Congress. It is to be expected that many of the bills in this last group will be reintroduced and considered by the 88th Congress which convened on January 9, 1963.[1]

1959

Public Law 86–372—The Housing Act of 1959 authorized a direct loan program providing up to 98 percent of development costs of nonprofit rental projects for the elderly for periods of not more than 50 years at low rates of interest; also authorized insurance of mortgages on rental projects for the elderly built by profit organizations (including mortgage insurance for proprietary nursing homes), and direct loans to nonprofit corporations to finance rental housing for the elderly; reduced the eligible age for public low-rent housing for low-income elderly persons to age 62 for women and age 50 for disabled persons; authorized the Public Housing Administration to assist in the construction or remodeling of low-rent public housing projects designed for older families; authorized costs exceeding the cost for regular units by as much as $500 per room; provided highest priority to elderly for admission to low-rent public housing units suited to their needs.

1960

Public Law 86–778—Social Security Amendments of 1960 made a number of major changes including: eliminating the age of 50 as a minimum to qualify for disability benefits; liberalizing the retirement test and the requirements for fully insured status. Changed the public assistance provisions to provide a new program of grants-in-aid to States for medical assistance for aged persons who are not recipients of old-age assistance but who have insufficient income for necessary medical services (Kerr-Mills); increased the Federal share of State old-age assistance expenditures and medical care.

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[1] The committee appreciates the assistance given it by the Department of Health, Education, and Welfare in compiling the list of legislation herein set forth.

93184—63——13

1961

Public Law 87-31—Public Assistance Amendments increased Federal financial participation in medical care expenditures for old-age assistance recipients and extended and increased authorization to 100 percent Federal support of State expenditures for training public welfare workers. (No appropriations for training.)

Public Law 87-64—Social Security Amendments of 1961 (*a*) lowered retirement age for men from age 65 to 62; (*b*) increased minimum benefits paid from $33 to $40; (*c*) broadened program to include 160,000 retired persons; (*d*) increased benefits to aged widows by 10 percent; (*e*) increased the amount a worker can earn without losing benefits.

Public Law 87-285—Railroad Retirement Act Amendments provided reduced annuities for males who retire at age 62, etc. (Brought RRA into line with social security.)

Public Law 87-395—Community Health Services and Facilities Act of 1961 provided formula grants to State health departments to establish and expand out-of-hospital community health services for the chronically ill and the aged; provided grants for State or other public and non-profit-making agencies for demonstrations of new and improved methods for providing health services outside the hospital.

Public Law 87-70—Housing Act of 1961 increased the authorization for direct loans for housing for the elderly from $50 to $125 million, and up to 100 percent of the development cost; made consumer cooperatives and public bodies eligible; raised the low-rent public housing authorization; lifted cost ceiling for units specially suited to the elderly by $500; established a new program to help finance housing for low and moderate income facilities of all ages, including the retired; authorized an additional $120 per dwelling unit as an annual Federal contribution to low-rent public housing occupied by senior citizens.

1962

The legislation described below was not limited exclusively to older persons in all cases; e.g., Revenue Act of 1962, but is clearly of significance to them; only those portions of the legislation relevant to aging are treated here. Laws which benefit older persons only as part of the total population are not listed, e.g., the strengthening of the Food and Drug Law (S. 1552).

Public Law 87-543—Public Welfare Amendments of 1962 (*H.R. 10606*).—To encourage old-age assistance recipients to contribute to their own support, an elderly man or woman may earn and keep up to $30 a month without deduction from the assistance check. In determining need, States may disregard the first $10 and half of the next $40 of monthly earned income.

To improve assistance payments to the aged the States may now increase the monthly average payments by about $4 beginning October 1 Also, the temporary $1 increase in Federal financial participation voted last year is made permanent. In effect, the maximum average amount subject to Federal sharing is increased from $66 to $70 a month. Since the additional $15 in old-age assistance for medical payments is continued, the total maximum for old-age assistance in which the Federal Government shares will be $85.

The new law emphasizes rehabilitative and social services to help the aged toward self-care. For such services as specified by the Secretary of Health, Education, and Welfare, the Federal share of the costs will be 75 percent rather than 50 percent. Further, while formerly the Federal Government could share only in costs of social services for applicants and recipients of public assistance, now Federal financial participation may be provided for services to former applicants and recipients and to those likely to become applicants or recipients for old-age assistance or medical assistance for the aged.

To help relieve the shortage of workers capable of providing skilled welfare services, the amendments provide for Federal training activities directly through grants or contracts with institutions of higher learning for short courses, seminars and experimental programs, and through special grants to States, although no appropriation was made to carry out these provisions. Additional training funds are available through the regular grants to the States for administration.

The Federal Government will pay 75 percent of the administrative costs of State-operated in-service training programs and grants for school attendance by welfare staff as compared to the 50 percent available formerly.

Public Law 87-723 (H.R. 12628) Senior Citizens Housing Act of 1962.—This act provides additional funds under section 202(a)(4) of the Housing Act of 1959, and amends title 5 of the Housing Act of 1949 in order to provide low and moderate cost housing, both urban and rural, for the elderly. The major changes accomplished through this legislation are in the rural housing program: direct loans, mortgage insurance, and grants are provided.

Section 3, Housing for the elderly (program administered by HHFA).—Amends section 202 of the Housing Act of 1959, the existing program of low interest, direct loans to provide rental housing for the elderly, by (*a*) increasing the total amount authorized to be appropriated for loans from $125 million to $225 million, (*b*) limiting loans under this section to new construction (not for rehabilitation of existing structures). This program enables the Administrator of HHFA to provide favorable terms (at present 3½ percent interest and a 50-year loan maturity) so that rental housing can be provided for the elderly at rents of $15 to $20 per month below projects financed either conventionally or with FHA insurance. Eligible applicants for loans are nonprofit corporations, consumer cooperatives, and certain public agencies.

Section 4, Housing for the elderly (program to be administered by the Secretary of Agriculture).—Subsection A broadens the existing rural housing program to authorize the Secretary of Agriculture through the Farmers Home Administration to make loans to elderly persons (62 or over) for the purchase of existing homes, or the construction, improvement, alteration, or repair of dwellings and related facilities in rural areas for their own use, including the purchase of land necessary as a minimum adequate site for such dwellings. Cosigners would be permitted in the case of elderly applicants who lack repayment ability. Subsection B adds a new section 515 to title 5 of the Housing Act of 1949 establishing a program of direct and insured loans by the Secretary to private nonprofit corporations and consumer cooperatives for the provisions of rental housing and related

facilities for elderly persons and elderly families of low or moderate income in rural farm and nonfarm areas. For this purpose, an additional authorization of $50 million is earmarked.

Loans could include the cost of land, as well as the structures. The interest rate would be comparable to the rate applicable under the HHFA program of rental housing for the elderly and the loans could have 50-year maturities. Loans could cover existing housing as well as new housing if it is rehabilitated or modified so as to be suitable for use by the elderly. Related facilities could include cafeterias, dining halls, community rooms and buildings, recreational facilities, and other service facilities.

Section 515 also establishes a new program under which the Secretary would insure loans to be made to individuals, corporations, and other entities to provide rental housing and related facilities for elderly persons and families in rural farm and nonfarm areas. Insured loans would be limited to $100,000. The duration of the mortgage would be within the discretion of the Secretary of Agriculture.

In another section the maximum amount of a grant and/or loan for improvements to rural housing is increased from $500 to $1,000. These grants are available to owner-occupants whose incomes are so low that they cannot qualify for loans from any source for improvements which are necessary to their health and safety or to the health and safety of the community.

Public Law 87–415—Manpower Development and Training Act of 1962 (S. 1991).—The purpose of the act is to appraise the manpower requirements and resources of the Nation and to develop and apply the information and methods necessary to deal with problems of unemployment resulting from automation, technological changes, and the growth of the labor force and other causes of persistent unemployment. The act provides for programs for evaluation, information, and research and developing of skill and training requirements to be used for purposes of educational training, counseling, and placement activities.

Research and studies related to the purposes of the act are authorized through contracts or agreements with public and private agencies, universities, and individuals.

This act authorizes a 3-year program to train the unemployed and upgrade the skills of the underemployed. Its objective is to reduce hard-core unemployment by enabling unemployed and underemployed workers, whose skills have become obsolete, to receive training which will equip them with skills needed in their area and State.

Training costs and training allowances of the unemployed are financed entirely by Federal funds through fiscal 1964. In 1965 financing is to be on a 50–50 Federal-State matching basis.

The Secretary of Labor has responsibility for a program of testing, counseling, and selection for occupational training; training allowances are provided under agreements with the States to unemployed persons selected for training for periods not exceeding 52 weeks and not exceeding the amount of unemployment compensation for which the trainee is eligible, or an amount not exceeding the average weekly unemployment compensation payment. Allowances are also provided for transportation and subsistence expenses where necessary not to

exceed $5 a day and 10 cents per mile. On-the-job training is also provided.

The Secretary of Health, Education, and Welfare is authorized to enter into agreements with States under which the State vocational education agencies will provide training needed to equip persons referred by the Labor Department for training in the specified occupations. State agencies provide such training through public education agencies unless these are not adequate, in which case arrangements may be made with private educational or training institutions. Workers in low income farm families are eligible for assistance.

The act may be expected to help middle-aged and older workers, since many of the unemployed are age 45 and over and are more heavily represented in the long-term unemployed.

Public Law 87-793—Postal Service and Federal Employees Salary Act of 1962 (H.R. 7927).—Part III, adjustment of annuities, raised annuities by 5 percent and provided for cost-of-living adjustment of annuities after January 1, 1964, for each year in which the price index rises at least 3 percent.

Public Law 78-792—An Act To Encourage the Establishment of Voluntary Pension Plans by Self-Employed Individuals (H.R. 10).—The act allows the self-employed to claim deductions on half the amounts they put into retirement pensions. Such contributions are limited to 10 percent of a person's income, with an annual ceiling of $2,500. The maximum annual deduction from income taxes would be half, or $1,250. If the self-employed person employs anyone else he must establish a comparable pension plan for his employees in order to be eligible for his own tax advantage.

Public Law 87-838—(H.R. 11099) Amendments to the Public Health Service Act for the Establishment of an Institute of Child Health and Human Development and for Other Purposes.—Section 441 authorizes the Surgeon General to establish in the Public Health Service an Institute for the conduct and support of research and training relating to maternal health, child health, and human development.

The original bill included the words "and the aging." However, the deletion of these words from the bill as enacted does not eliminate research in aging. That "human development" will be interpreted to include aging is clear in the legislative history. For example, in the report of the Senate Committee on Labor and Public Welfare it states:

> There will be emphasis * * * on the special health status and needs of particular segments of the population * * * aged persons.

It further states that the program of the Institute will give attention to the stages of maturation and aging and will encompass research and training in the biological, medical, and behavioral aspects of aging.

Public Law 87-863—(H.R. 10620) Increasing the maximum limitations on the amount allowable for medical and dental care and (H.R. 10117) to provide the plans which provide medical and other benefits for retired employees may be qualified pension plans.—The maximums on deductible medical expenses for purposes of income taxes are raised under this bill for all taxpayers, and to as much as $40,000 if the tax-

payer and his spouse are aged 65 or over and are disabled. Chief benefits are to those with high income and high medical expenses. It also permits annuity plans which include accident, health, sickness, and medical benefits for retirees to qualify for tax savings.

Public Law 87–876—Limitation on Retirement Income Credit—(H.R. 6371).—This act changes the limitations in the retirement income credit to conform to the limitations in the Social Security Act, as amended. There are three principal changes: (1) The maximum amount of retirement income permitted to qualify for the credit is increased from $1,200 to $1,524; (2) reduction for earned income is modified so that there will be no reduction for the first $1,200, a reduction of 50 cents for each dollar of earned income between $1,200 and $1,700 and a dollar-for-dollar reduction of earned income of more than $1,700; and (3) individuals aged 62 to 65 will be able to use the same earned income procedure.

The maximum credit under this act will be $304.80. A single taxpayer aged 65 who has interest income of $3,027 would not have to pay any Federal income tax. Previously, he would have had to pay on over $2,667 earned income. In effect, this act creates equal conditions for persons who are not under social security benefits but who are retired under Government or private pension programs.

1962 BILLS OF SPECIAL INTEREST—NOT ENACTED

In two major areas, there were a number of bills which may be expected to be reintroduced in the same or similar form in the next session of Congress. The most important area was health insurance for the aged. The other was the category of general bills relating to the organization of Federal activities and to grants-in-aid in the field of aging. These were the subject of hearings and/or debate. The brief descriptions which follow can be supplemented by the references indicated in the paragraphs below:

A. Health insurance proposals

These proposed bills fell into three major categories: (*a*) Health insurance benefits for social security beneficiaries through OASI; (*b*) Federal grants to States to provide health insurance to the aged with limited incomes; (*c*) credit against income tax for medical care insurance premiums. A committee print prepared by the Special Committee on Aging of the U.S. Senate, entitled, "Comparison of Health Insurance Proposals for Older Persons 1961–62" charts the features of six bills. The administration supported King-Anderson bill (H.R. 4222 and S. 909) would provide hospitalization, nursing homes, home health services, drugs, and outpatient diagnostic services, using the mechanism of social security for financing. Little difference of opinion occurred with respect to the types of benefits. The major issue was social security financing. The McNamara bill (S. 65),

the Javits bill (S. 2664), and the Lindsay bill (H.R. 11253) would add general revenue financing for the uninsured, with some sharing by the States in the case of the Lindsay bill. The Bow bill (H.R. 10755) would be financed entirely from general revenues.

The King-Anderson bill (H.R. 4222) was introduced early in the first session. In the second session the Anderson bill, with the support of 25 other Senators, was introduced as an amendment to H.R. 10606, the public welfare bill, with certain major modifications: (*a*) Payment of health insurance benefits from general revenues for aged persons not eligible under OASI; (*b*) use of approved private organizations in the administration of the program; and (*c*) an option under which beneficiaries could receive benefits through private plans rather than Government. Several other amendments were approved on the floor of the Senate, including one by Senator Javits relating to an option to continue private health insurance protection. The entire amendment was tabled in the Senate, by a vote of 52 to 48. (See Social Security Bulletin, October 1962, vol. 25, No. 10, pp. 17–21, for a discussion of proposals for health insurance for the aged.)

B. Organization of Federal activities in aging and grants-in-aid

Hearings were held in the House of Representatives in 1962 by the General Subcommittee on Education under the chairmanship of Congressman Cleveland Bailey on H.R. 10014 and some 13 other bills having to do with the organization of Federal activities in the field of aging and for with grants-in-aid to promote programs, training, or research in the field of aging.[2]

The major point at issue involved the question of whether or not the activities of the Federal Government in the field of aging are now given sufficient emphasis, properly coordinated and effectively administered or whether, to achieve these goals it is desirable to create a U.S. Commission on Aging under the President as recommended by Senator McNamara and Congressman Fogarty rather than under one of the several departments concerned. A second important point at issue was whether or not Federal grants-in-aid should be made to and through State commission on aging or similar bodies. In other respects the bills are fairly similar in their objectives and in the activities they would support. The major provisions of the typical bills are indicated in the chart "Typical Provisions of Bills Relating to Federal Activities in Aging."[3]

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[2] An identical bill, companion to Congressman Fogarty's H.R. 10014, was introduced in the Senate by Senator McNamara as S. 2779. For a more extended discussion of the major point at issue in these bills, see ch. 5.

[3] The hearings on these bills are available in the volume, "Problems of the Aged and Aging," pt. 1, 1962, prepared for the Committee on Education and Labor, House of Representatives, Washington, D.C.

Typical provisions of bills relating to Federal activities in aging

Bill Nos.	H.R. 10014; S. 2779	H.R. 10870	H.R. 11752	H.R. 12799
Sponsor	Fogarty-McNamara.	Yates	Bailey	O'Hara.
Provisions:				
(A) Grants to States	Yes	Yes	No	Yes.
1. For planning	$2.09 million	$2 million		
2. For projects	$50 million, 5 years	$19 million, 4 years		$30 million, 3 years.
3. Matching	25 percent, 2 years. 50 percent, 3 years.	~~⅓-⅔~~		Flexible.
4. For State administration.	$15,000 to $25,000.			$25,000 maximum.
5. Population formula	Yes	Yes		Yes.
(B) Grants to nonprofit agencies.	Yes	Yes	Yes	No.
1. For research, demonstration and training.	$2 million	$500,000	$50 million, 5 years.	
2. Matching	Flexible	Indefinite	Flexible	
(C) Appropriated amount	$54.09 million	$21.5 million	$50 million	$30 million.
Duration	5 years	4 years	5 years	3 years.
(D) Advisory committee	Yes, 20 members	Yes, Number unspecified.	Yes, 30 members	None.
(E) Interdepartmental committees.	Yes			
(F) National conference	No	By 1967	No	No.
(G) Administered by	Commission	HEW	HEW	HEW.

Miscellaneous bills not enacted

The following bills have been selected as representative of the variety of legislative proposals introduced during this session. Some, like the amendments to the Revenue Act which would have exempted from taxes capital gains on the sale of housing by elderly persons, and the veterans' pension bill, had considerable discussion and support in the Congress. Others were not reported out of the committee to which they were assigned nor were hearings conducted.

H.R. 9546 would provide minimum benefits under the old-age and survivors insurance program at age 72 for individuals who are not entitled to benefits or retirement under other Federal or State laws.

H.R. 9855 would authorize the payment of old-age insurance benefits to all individuals who attained age 70.

H.R. 9839 would remove the limitation upon the amount of outside income which may be earned while receiving benefits under social security.

H.R. 12366 would increase from $1,200 to $1,800 a year and from $100 to $150 per month outside earnings permissible without deduction from social security benefits.

H.R. 10337 would amend the Social Security Act to provide benefits for dependent parents of persons entitled to OASI benefits.

H.R. 11596 would permit an individual fully insured under OASI to elect exclusion of any employment performed after attaining retirement age.

H.R. 11390 would provide social security retirement benefits for men at age 62 and women at age 60 and would establish a hospital and surgical insurance program.

H.R. 13323 would permit an individual to obtain coverage under title 2 of the Social Security Act on the basis of service which was

not covered employment at the time it was performed if service of that type has since become covered employment and the individual makes payment of the applicable social security taxes.

S. 2666 (H.R. 10731-H.R. 9724): These bills would exclude from gross income any capital gains realized from the sale or exchange of the principal residence of a taxpayer aged 65 or older, if he has used the home as his principal residence for a period of not less than 5 years. The destruction, seizure, requisition, or condemnation of property would be treated like the sale or exchange of such property.

H.R. 9931 would provide an additional exemption of $3,500 for a taxpayer filing a joint return where both husband and wife are age 65, an additional exemption of $2,000 for an unmarried taxpayer age 65.

H.R. 12110 would allow an employer a credit against income taxes equal to the increases in his cost of doing business resulting from the employment of older persons.

S. 2811 (H.R. 12931-H.R. 12278): These bills would provide that the sworn statement of claimant for medical assistance for the aged with regard to financial status would be presumed by any State agency to be factually correct for the purpose of determining eligibility, or would amend the Social Security Act to prohibit any State from applying a means test in determining eligibility for medical assistance to the aged.

H.R. 11108 would provide hospital care for war veterans 70 years old without requiring submittal of a statement under oath of their inability to defray expenses.

H.R. 3745 would provide a pension of $100 a month to all veterans of World War I without regard to income.

S. 3712: This bill would assist in the provision of housing for elderly persons in a variety of ways. It would provide home improvement loans with the possibility that the elderly borrower would pay interest only during his lifetime; provide mortgage insurance for nonprofit nursing homes up to 100 percent of cost; provide grants on a matching basis for long-range urban planning to meet the needs of the elderly; make public housing agencies eligible for direct loans for housing of the elderly; meet problems regarding the relocation of elderly persons from urban renewal areas and study the need for rent supplemental programs; make grants to permit the use of relatively costly land in urban renewal areas for housing for elderly persons; and provide a different way of accounting for expenditures for these purposes in the budget.

House Joint Resolution 629 would proclaim May as Senior Citizens' Month.

1962—Summation

During the 1962 session of Congress, approximately 160 bills related to older persons were introduced (as of September 30) and 8 were enacted. All pending legislation which failed final enactment died with the 87th Congress.

I. Subjects of legislation introduced

Based on inspection of bills listed in the index of the "Digest of Public General Bills," the approximate frequency of the subjects were:

	Bills
A. Social Security Act changes	56
(1) Extension of benefits	16
(2) Liberalization of deductions due to work	14
(3) Disability benefits	10
(4) Health Insurance under social security	10
(5) Old-age assistance	3
(6) Increase in benefits and lowering retirement age	3
B. Tax benefits	50
(1) Medical care insurance premiums income tax credit	35
(2) Sale of home, capital gains, exemption from gross income	6
(3) Others, including increase in deductions and exemptions	9
C. Civil service and railroad retirement (mainly increases) and veterans' pensions	40
D. Housing	8
E. Federal organization and aid to States	4
F. Employment	3

INDIVIDUAL VIEWS OF SENATOR GEORGE A. SMATHERS

Senator George A. Smathers, Democrat, of Florida, due to other legislative duties, has not read this report and makes no comment with respect to the views expressed or recommendations made. Accordingly, the report has not been signed by him.

MINORITY VIEWS OF SENATOR EVERETT McKINLEY DIRKSEN, SENATOR BARRY GOLDWATER, SENATOR FRANK CARLSON, AND SENATOR WALLACE F. BENNETT

The strong desire of most older people for independence has been reasserted vigorously during the 2 years since the formation of the Special Committee on Aging.

This preference to live their own lives with minimum interference from government at any level, whatever the guise, has been manifest in many ways including numerous letters to the Congress.

Solutions of those problems which now confront some older people, therefore, should be developed in ways which will reinforce private initiative, individual responsibility and personal liberty for older persons wherever possible.

Preservation of uniquely American institutions and processes which operate most effectively toward these ends becomes doubly important in light of the dramatic ways these methods are responding to demands imposed by the new era of aging.

Since the major problems among the aged are largely economic, highest priority should be given to those actions by the Government which would—

(1) Increase social security payments, especially minimum benefits;

(2) Permit persons over 65 greater flexibility in their use of social security without loss of benefits;

(3) Increase employment opportunities for older people and reduce elements in Government policies and programs which interfere with senior citizens' full use of opportunities which now exist;

(4) Pursue policies to encourage rapidly growing private programs for helping people prepare for the economic requirements of later years;

(5) Eliminate unnecessary Government spending and thereby reduce the already serious impact of inflation on retirement income.

Concurrently, efforts should be accelerated to achieve full implementation of programs already enacted by Congress to meet the needs of older people who may now be confronted with special hardships.

The majority's report supports in principle a proposal by Senator Dirksen and others that older people who sell their homes in order to secure housing better adapted to their needs should not be subject to a capital gains tax on such a transaction. The substance of a bill introduced by Senator Dirksen was adopted as an amendment to the Internal Revenue Code by the Senate, in the 87th Congress. However, the House and Senate conferees did not retain the provision. A similar measure has been reintroduced in the 88th Congress, and it should receive prompt consideration.

POINT I: INCREASE SOCIAL SECURITY PAYMENTS, ESPECIALLY MINIMUM BENEFITS

The social security program was conceived to establish benefits that would provide an income floor for retired individuals so that normally they would not become dependent on others for support. It was always expected that individuals should supplement their social security benefits by savings and other investments, including insurance, to provide a more rewarding standard of living during their later years.

Benefits will automatically increase in future years as they reflect the higher earnings of those presently employed. Average annual earnings are considerably greater than they were even a few years ago. Nevertheless, an increase in the minimum benefits for those presently retired, where benefits reflect their earnings during periods of lower income, lower living costs and in many cases years of depression, should be considered so that the OASDI may more effectively meet the needs which Congress expected to provide at the time of its enactment.

POINT II: PERMIT PERSONS OVER 65 GREATER FLEXIBILITY IN THEIR USE OF SOCIAL SECURITY WITHOUT LOSS OF BENEFITS

Rigid limits on permissible earnings while receiving social security benefits now severely restrict the 65-year-old person in tailoring the Federal program to his own individual needs.

Latitude is now given those whose personal situations make it desirable to retire before 65. Consideration also should be given to how similar freedom might be best accorded those who prefer to retire at later times.

Whether this is to be achieved through changes in the rule that a person can earn only $1,200 a year without affecting his social security benefits, through paying him substantially higher benefits if he defers retirement, or through other changes in the program should receive careful consideration from the Congress.

Related to this is the whole question of retirement at 65, particularly on a compulsory basis. In the light of new and emerging knowledge, the impropriety of current retirement practices deserves special attention in drafting public policies.

POINT III: INCREASE EMPLOYMENT OPPORTUNITIES FOR OLDER PEOPLE AND REDUCE ELEMENTS IN GOVERNMENT PROGRAMS WHICH INTERFERE WITH SENIOR CITIZENS' FULL USE OF OPPORTUNITIES WHICH NOW EXIST

Despite the fact that over one-third of the male population and one-tenth of the female population aged 65 and over are currently in the Nation's work force,[1] it is evident from the testimony before the Special Committee on Aging and other sources that many more would like to continue working on a part-time or full-time basis.

Two factors seem important in causing the 40-percent reduction in the percentage of employed males past 65 between 1930 and 1960,[2]

[1] Source: "New Population Facts on Older Americans, 1960," a staff report to the Special Committee on Aging, U.S. Senate, May 24, 1961, p. 22.
[2] Ibid.

(1) more widespread compulsory retirement at 65 and 2 increasingly restrictive employment practices related to age.

Both of these should be subjected to close scrutiny by business, labor, and other key elements of society.

As life expectancy constantly increases, and with it comes a greater physical and mental capacity at all ages, it would appear wise to carry out an intensive educational campaign directed at removal of unwarranted barriers based on age. To do so would serve both the Nation and millions of older people as individuals.

Also in order is a review of how Government programs and such policies as those relating to taxation may affect employment opportunities for older people.

Individual testimony before the committee indicates that current rigidity of the social security program itself, particularly regarding earnings limitations, may be a major factor in discouraging persons past 65 from remaining in productive employment even though they want to work and have the capacity to do so.

Careful appraisal of this possibility should be made along with similar examination of other Government programs and tax laws which might also have such effects, often to the serious disadvantage of the individual.

It should be noted that, in the case of social security, the major impediments appear to affect most severely those between the ages of 65 and 72 when a high proportion retain full vigor and competence.

POINT IV: PURSUE POLICIES TO ENCOURAGE RAPIDLY GROWING PRIVATE PROGRAMS FOR HELPING PEOPLE PREPARE FOR THE ECONOMIC REQUIREMENTS OF LATER YEARS

That great changes in the economic status of older people is in prospect through private efforts is evident from rapid growth in all types of savings, but it is especially significant in developments related to private pension plans.

Roger F. Murray, professor of banking and finance, Columbia University Graduate School of Business, in his appearance at a committee hearing in 1961, said:

> During the past decade, there has been an explosive growth in the number of people covered by retirement plans designed to supplement their prospective benefits under the old-age and survivors insurance system. The number of covered *employees* in private industry, for example, is currently about 22 million, representing a growth of close to 50 percent in the last 5 years. In Federal, State, and local governments, of course, the coverage is close to completion.[3] (The latter category embraces over 10 million employees.)

A more comprehensive summary of this growth is contained in the report by the House Committee on Education and Labor on H.R.

[3] Source: "Retirement Income of the Aging," hearings before the Subcommittee on Retirement Income of the Special Committee on Aging, U.S. Senate, 87th Cong., 1st sess., pt. 1, July 12–13, 1961, p. 157.

8723, 87th Congress, amending the Welfare and Pension Plans Disclosure Act, which stated:

> Figures relating to pension plans show that their number grew from 7,400 in 1945 to an estimated 25,000 in 1960, while the number of persons covered moved from 5.6 million to approximately 80 million.
>
> Tabulations introduced into the record of the subcommittee hearings show that in 1959 the assets of both welfare and pension plans amounted to over $50 billion; and that they were growing at a rate of from $4 to $5 billion a year.
>
> It is clear that these plans have now become, on the one hand, a cornerstone to the protection of many millions of our citizens and their families; and, on the other, a vast and continously increasing body of funds, which exercises a significant effect on the national economy.[4]

The 87th Congress enacted H.R. 10, a measure which will enable self-employed individuals to establish pension plans for themselves. In order to enjoy these benefits, however, they must also provide for their own employees. The stimulus thus given to retirement programs for the self-employed *and their employees* should accelerate further the expansion of private pensions.

Paralleling the rapid expansion of pension programs has been the growth of mechanisms for protecting older people from the financial impact of illness.

The most economic solution to the problem of providing medical care for any individual is the establishment of a program early in life to cover hospital, medical, and surgical care through guaranteed renewable lifetime plans developed by the insurance industry. Provision of coverage before attaining age 65 permits establishment of lower premium charges. In recent years, many employers have provided group policies which include provision for continuing benefits following retirement. The number of individuals covered by such policies has grown at a phenomenal rate.

Other plans have been made available recently to meet the needs of senior citizens. These plans, providing hospital and surgical expense benefis to those over 65, are offered under a mass enrollment technique. Applicants are eligible irrespective of their past medical histories and without medical examinations. Some plans, however, require the newly insured person with a preexisting health condition to wait 6 months before benefits are available for that particular condition. Protection of these plans cannot be terminated for any individual policyholder—only for State residents as a group. Similarly, premium charges can only be adjusted for an entire group—not on an individual policyholder basis.

The Health Insurance Institute, in a release dated October 25, 1962, comments specifically on these efforts to bring the savings inherent in group underwriting to individual policies. It states:

> One of the first to use the mass enrollment technique was Continental Casualty which put its first program into effect in 1957. The company, during the month of October, is

[4] "Welfare and Pension Plan Amendments of 1961," report to accompany H.R. 8723, 87th Cong., 1st sess., p. 4.

> holding its 19th open enrollment period, making its health insurance coverage available at this time to the residents of 48 States. Continental Casualty reported at the beginning of this year that it was providing health insurance coverage to more than 1,200,000 persons 65 or older.
>
> Mutual of Omaha currently is holding its eighth national open enrollment. The company, which has reported it covers more than 1,250,000 men and women 65 and over, is holding its enrollment period from October 1 through November 15, 1962. Mutual of Omaha has stated that during its last enrollment period it received total applications of more than 101,000.[5]

Despite such evidence, efforts to disparage these new developments continue, including persistent statements that no more than 500,000 persons are covered through these new plans.

The fact is that several companies are each providing coverage through such mass enrollment techniques to more than 1 million people.

In its October 25, 1962, release, the Health Insurance Institute also stated:

> In 1952, an estimated 26 percent of the aged had some form of private health insurance coverage through insurance coverage, Blue Cross-Blue Shield, and other health care plans.
>
> Now it is estimated that 55 percent of the total noninstitutionalized aged population are protected, the Institute declared. This adds up to more than 9 million persons 65 and over who have health insurance, including some 4.75 million elderly covered by insurance companies.[5]

During the past 9 years the proportion of the older population with health insurance has more than doubled and the number covered has tripled.

In 1962 a measure introduced by Representative Curtis of Missouri, H.R. 10117, proposed that employers who provide medical and other benefits for their retired employees and families, in accordance with regulations prescribed by the Secretary of the Treasury, may regard such costs as contributions to other qualified pension plans. The substance of this bill was included as an amendment on the Senate floor to another revenue measure, and it has been signed into law.

Unquestionably this action will provide additional impetus to the growing practice of including health benefits as part of private pension programs.

In view of the rapid strides being made by voluntary health insurance in coverage of older people, the urgency with which some would rush through Congress a federally administered scheme financed by higher social security taxes becomes understandable.

Their fear is apparent that but a short time remains before voluntary efforts will have fully met the needs of most older people.

Antagonism, overt, and insidious, to such congressionally approved programs as the Kerr-Mills Act for supplementing voluntary health insurance reinforces this suspicion.

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[5] Press release, Health Insurance Institute, October 25, 1962.

There are three basic objections to providing medical care for people over 65 as part of the social security system. They are:

(1) Such a program would constitute a partial nationalization of health services which may seriously endanger our voluntary medical system.

(2) As a compulsory program embracing all people in this group without regard for whether they want or need proposed government services, it would involve a major infringement on individual responsibility and liberty.

(3) There is serious question whether it is proper to use Federal tax money to purchase such service for an individual without regard for his actual need.

These objections were responsible for the rejection of proposals of this type by Congress in 1960 and again in 1962 as well as in its determination in 1960 to enact the Kerr-Mills program into Public Law 86–778.

The Kerr-Mills Act provides Federal funds for State-administered medical programs for the aged who need help, with three important elements:

(1) Grants to the States under this program are unusually generous.

(2) Each State is free to develop virtually any plan which will best meet the needs of its citizens.

(3) Eligibility for medical assistance and the determination for its need is entirely at the State's discretion.

A number of bills were introduced in the 87th Congress which would avoid some of the obvious defects in providing medical services through the social security system. Among them were proposals introduced by Senator Morton, Senator Bush, Representative Bow and others for tax credits and/or cash subsidies for purchase of voluntary health insurance, and by Senator Saltonstall and others for a State-administered medical program available to older persons with annual incomes under $3,000.

It would appear prudent, however, to defer action on any new proposal until the effectiveness of the Kerr-Mills Act can be evaluated fully. A vigorous, imaginative administration of the program by the executive branch is necessary if such an appraisal is to be meaningful. It is evident that, in its eagerness to impose a total compulsory health scheme on the elderly, the present administration has deliberately downgraded the values inherent in the Kerr-Mills approach.

The Congress wisely recognized that the States are in the most advantageous position to establish the standards for the administration of this program. Their legislatures are responsive to the varying demands of the local communities within the States.

This fact is acknowledged in the majority's report in its discussion of Public Law 87–395, the Community Health Services and Facilities Act of 1961. It quotes President Kennedy's statement, when he signed this measure into law, to the effect that—

> * * * It will help place the best available knowledge in health care at the disposal of communities by increasing Federal assistance to State and local public health services.

> Effective public health measures and medical care depend, in the last analysis, on action at the community level.[6]

President Kennedy's position that the furtherance of health and welfare programs can be accomplished best by encouraging the citizens in their local communities is a sound one, and this philosophy was embodied in the Kerr-Mills Act.

The uncertainties generated by the administration's support for alternative proposals to provide medical assistance for the aged through the social security program, has discouraged some States in adopting the necessary legislative and administrative measures to implement State programs which would take full advantage of the liberal Federal assistance which the Kerr-Mills Act provides in helping the States to meet the medical needs of their older people.

Nonetheless substantial progress has been made. In fact the speed with which State programs are being put into effect exceeds that of any previous program providing grants-in-aid to the States.

The Congress should take further action to improve existing programs and provide greater equity for our citizens.

Progress can be made without compromising in any way the necessity of encouraging each individual in his productive years to provide himself adequate income to meet the needs of retirement with dignity and with access to the medical advances which modern science provides.

POINT V: ELIMINATE UNNECESSARY GOVERNMENT SPENDING AND THEREBY REDUCE THE ALREADY SERIOUS IMPACT OF INFLATION ON RETIREMENT INCOMES

The continued increase in Government spending has been the primary factor responsible for inflationary pressures on our economy.

Our present elder people, who, through prudent savings, believed that they had adequately provided for their future needs, discovered that the purchasing power available to them was less than half of what they had expected.

The majority's report suggests a possible solution by the issuance of a Government bond which would guarantee redemption with dollars of equivalent purchasing power. Such a proposal would only encourage further deficit spending and eventually destroy our free enterprise society.

The President's proposals to reduce tax rates are a recognition that the American people have too long supported a level of Government expenditures which interferes with adequate savings for the worker.

Payroll taxes under the social security program, are in effect a direct tax on employees with no deductions or exemptions. The employer's share of the social security tax ultimately must be included in the price of goods and services, as he cannot make such payments out of capital without destroying his solvency.

Now that we are meeting intense foreign competition, costs, which must include all taxes, become of great concern and directly affect the employment level, the income workers may receive, the cost of living, and their ability to save for the future.

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[6] "Development in Aging, 1959–63," a report of the Special Committee on Aging, U.S. Senate, pursuant to S. Res. 238, Feb. 7, 1962, p. 42.

The Federal Government can make no greater contribution to the welfare of every citizen—those in the working force, and those retired—than through the exercise of strict economy and by relinquishing activities which it has assumed that more properly should be performed by the States themselves.

CONCLUSION

The Special Committee on Aging has performed a service in developing information over the many fields which have been explored. The committees of the Congress with legislative authority and jurisdiction will have the benefit of sharing the experience of those who have been seriously concerned with the problems affecting this important sector of the population. Since every citizen contributes to the support of the aged and at a later date will be included in this group, every effort must be made to improve existing programs. We must observe the changing trends in our economy and appraise their significance for the future to maintain economic growth and insure equity for all.

Our citizens throughout our history have been dedicated to the preservation of family values which are recognized by our religious and civic leaders. This generation is ready and willing to discharge its responsibilities to those who are aged and require assistance. The Congress must insure, however, that our younger people are given the opportunity to fulfill this obligation without destroying their ability to enjoy the blessings of a free enterprise society. Private initiative is already diminishing the need for public assistance for our younger workers when they reach retirement. This progress can only be continued by frugality in government and a reduction in excessive burdens of taxation which have continued for so many years.

The minority believes that older people want opportunity. Opportunity to work; opportunity to retire with confidence that their income will not be eroded by rising taxes and inflation. Opportunity to live as free and independent citizens. It is in assuring such opportunity that the challenge to America lies.

INDIVIDUAL VIEWS BY SENATOR JACOB K. JAVITS

The report of the Special Committee on Aging presents a sound, well-documented analysis of the circumstances and needs of the retired and aging section of the American population which are causing increasing concern. Its recommendations for coordinating existing Federal programs in aging deserve very careful consideration. It is understandable and necessary that the Federal Government should play an essential role in the solution of the problems of health care, special housing, construction of medical facilities, taxable income and others faced by Americans 65 years of age and older.

The purpose of these supplementary views is also to recognize that private enterprise is a vitally important partner in this overall effort and can assume tasks that, if not undertaken by private enterprise, would necessitate further Federal expansion in this field. The entire burden and responsibility for meeting the needs of our senior citizens should not fall solely on the Federal Government.

The main report takes account of this role but does not visualize its expansion or capabilities. The role of voluntary agencies, for example, can be expanded very considerably, especially if areas of cooperation can be developed with local public health and welfare authorities. Private enterprise is providing in Florida, in Arizona, in California, and in many other States some of the best housing for the elderly to be found in any country; it has made considerable effort to meet the need for skilled nursing facilities and for other aspects of retirement living. Private enterprise efforts to meet the need for health care services has taken many forms—insurance policies are only one of the number of approaches to this problem—group practice units, service plans, and various other programs, some of them frankly experimental, offer different approaches.

In all of these areas considerably more progress can be made with Federal assistance. A Federal floor of basic benefits for health care needs of the aging, for example, would make it possible for private insurance or other coverage on a supplementary group basis to provide adequate medical care including physicians' services at a cost that all but the indigent aged can afford. There is an infinite number of variations in the kind of preventive or ancillary care that private insurance or other health care coverage could provide if there were a basic floor of Federal hospital and health care benefits. This potential of private participation should be fully explored in all the areas covered by the majority report.

SUPPLEMENTAL VIEWS OF SENATOR WINSTON L. PROUTY

The fact that President John F. Kennedy has submitted a peacetime budget of $98.8 billion, which exceeds for the first time in history the previous high that occurred during World War II, is a matter of deep concern to all people with low incomes, particularly those in their declining years.

The deficits which occurred during the first 2 fiscal years of the Kennedy administration and the White House estimates for fiscal years 1963 and 1964 add up to a staggering overall deficit of $31 billion during the first 4 fiscal years of the present administration.

Continued extravagant spending of gigantic proportions will start another cycle of inflation and erode the value of the dollar which has been relatively stable for the past 4 or 5 years.

Uncontrolled spending which causes inflation has its most telling effects on older people who live on pensions, annuities, and dividends. If the present trend keeps on, retired folks will have fewer groceries on the shelf and be unable to afford some of the bare necessities.

APPENDIX A

Committee and Subcommittee Publications

One Asterisk Indicates Supply Exhausted. Copies are Available for Purchase From Superintendent of Documents, Government Printing Office, Washington, 25, D.C. Two Asterisks Indicate All Supplies Exhausted

PRINTS AND REPORTS

* Aged and Aging in the United States: A National Problem, Report No. 1121, February 15, 1960. (Cat. No. Y4.L11/2:Ag 3/7, $1.25)

Aged and Aging in the United States: A National Problem, summary and recommendations of Report No. 1121, February 15, 1960.

Action for the Aged and Aging, Report No. 128, March 28, 1961.

Action for the Aged and Aging, summary and recommendations of Report No. 128, 1961.

Developments in Aging, 1959 to 1963, Report No. 8, February 8, 1963.

Mental Illness Among Older Americans, committee print, September 8, 1961.

* New Population Facts on Older Americans, 1960, a staff report, May 24, 1961. (Cat. No. Y4.Ag 4:P81, 20¢)

Aging Americans, Their Views and Living Conditions, a staff report, December 1960.

The Condition of American Nursing Homes, a study, 1960.

The Aged in Mental Hospitals, a report, 1960.

* Comparison of Health Insurance Proposals for Older Persons, 1961–62, committee print, May 10, 1962.

* Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 3, 1961.

The Farmer and the President's Health Program, excerpt from the Congressional Record, May 17, 1962.

* Performance of the States, 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print, June 15, 1962.

* State Action To Implement Medical Programs for the Aged, a staff report, June 8, 1961. (Cat. No. Y4.Ag 4: M 46, 35¢)

* Health and Economic Conditions of the American Aged, a chart book, June 1961. (Cat. No. Y4.Ag 4: H 34/3, 15¢)

A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 31, 1961.

Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of HEW, May 24, 1962.

Statistics on Older People, Some Current Facts About the Nation's Older People, excerpt from the Congressional Record, June 14, 1962.

* Basic Facts on the Health and Economic Status of Older Americans, June 2, 1961. (Cat. No. Y4.Ag 4: #34/2, 15¢)
**Some Current Facts About the Nation's Older People, fact sheet, October 2, 1961.
The 1961 White House Conference on Aging, basic policy statements and recommendations, May 15, 1961.
Directory of Voluntary Organizations in the Field of Aging, a report, December 1960.
* A Survey of Major Problems and Solutions in the Field of the Aged and the Aging, 1959. (Cat. No. Y4.L 11/2:Ag 3/6, $2.00)
Housing for the Elderly, a report, August 31, 1962.

GENERAL

Background Studies Prepared by State Committees for the White House Conference on Aging (1960) (Cat. No. Y4.L 11/2: W 58, prices listed individually):
*Part 1, Alabama, Alaska, Arizona, Arkansas, California, Colorado. ($2.25)
*Part 2, Connecticut, Delaware, District of Columbia, Florida. ($2.50)
*Part 3, Georgia, Hawaii, Idaho, Illinois, Indiana. ($2.75)
*Part 4, Iowa, Kansas. ($2.75)
*Part 5, Kentucky, Louisiana, Maine, Maryland, Massachusetts. ($2.75)
*Part 6, Michigan, Minnesota. ($2.75)
*Part 7, Mississippi, Missouri, Montana. ($2.75)
*Part 8, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico. ($2.75)
*Part 9, New York, North Carolina, North Dakota, Ohio. ($2.50)
*Part 10, Oklahoma, Oregon, Pennsylvania. ($2.50)
*Part 11, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee. ($3.25)
*Part 12, Texas. ($3.25)
*Part 13, Utah, Vermont, Virgin Islands. ($2.75)
*Part 14, Washington, West Virginia, Wisconsin, Wyoming. ($3.25)

HEARINGS

Housing Problems of the Elderly:
*Part 1, Washington, D.C., August 1961. (Cat. No. Y4.Ag 4: H 81, 35¢)
Part 2, Newark, N.J., October 16, 1961.
Part 3, Philadelphia, Pa., October 18, 1961.
Part 4, Scranton, Pa., November 14, 1961.
Part 5, St. Louis, Mo., December 8, 1961.
Subcommittee on Involuntary Relocation of the Elderly:
Part 1, Washington, D.C., October 22, 1962.
Part 2, Newark, N.J., October 26, 1962.
Part 3, Camden, N.J., October 29, 1962.
Part 4, Portland, Oreg., December 3, 1962.
Part 5, Los Angeles, Calif., December 5, 1962.
Part 6, San Francisco, Calif., December 7, 1962.

Problems of the Aging (Federal-State activities), Federal Programs for the Aged and the Aging, hearings, July 23, 28, 29, 30, 1959:
*Part 1, Washington, D.C., August 1961. (Cat. No. Y4.Ag 4:Ag 4, 60¢)
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.

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.

Retirement Income of the Aging:
**Part 1, Washington, D.C., July 1961.
Part 2, St. Petersburg, Fla., November 6, 1961.
Part 3, Port Charlotte, Fla., November 7, 1961.
Part 4, Sarasota, Fla., November 8, 1961.
Part 5, Springfield, Mass., November 29, 1961.
Part 6, St. Joseph, Mo., December 11, 1961.
Part 7, Hannibal, Mo., December 13, 1961.
Part 8, Cape Girardeau, Mo., December 15, 1961.
Part 9, Daytona Beach, Fla., February 14, 1962.
Part 10, Fort Lauderdale, Fla., February 15, 1962.

The Aged and Aging in the United States (the Community Viewpoint):
**Part 1, Washington, D.C., June 1959.
Summary of expert views, June 1959 (summary of pt. 1).
Part 2, Boston, Mass., October 13, 1959.
Part 3, Pittsburgh, Pa., October 23, 1959.
Part 4, San Francisco, Calif., October 28, 1959.
Part 5, Charleston, W. Va., November 3, 1959.
Part 6, Grand Rapids, Mich., November 16, 1959.
Part 7, Miami, Fla., December 1, 1959.
Part 8, Detroit, Mich., December 10, 1959.

**National Organizations in the Field of Aging, hearings, August 4, 5, and 6, 1959.

**Health Needs of the Aged and Aging, hearings, April 4, 5, 6, 11, 12, and 13, 1960.

**Health Needs of the Aged and Aging, highlights of testimony, April 11–13, 1960, Washington, D.C.

Frauds and Quackery Affecting the Aging:
Part 1, Washington, D.C., January 15, 16, and 17, 1963.

APPENDIX B

Examples of the Effect That Unemployment Could Have on Retirement Benefits Under the Old-Age, Survivors, and Disability Insurance Program [1]

The benefit amounts shown in the attached examples are based on the worker's average monthly earnings using a number of years that is five less than the number of years elapsing after 1950 and up to the year in which he attains age 65:

Worker's age in 1962:	*Number of Years used in computing average monthly earnings*
40	31
45	26
50	21
55	16
60	11

The years used are always those after 1950 in which earnings were highest.

I. A man earns maximum covered earnings in each year, 1951–62, inclusive. He continues to work in covered employment after 1962 and up to the year he reaches age 65, under specified patterns of employment, with the following effects on the monthly benefit amount payable to him beginning at age 65.

[1] Prepared by Division of Program Analysis, Bureau of Old-Age and Survivors Insurance, Social Security Administration.

Worker	Man reaches age 65 in January	Number of months worked each year, 1963 on	Monthly rate of pay	Total covered earnings each year, 1963 on	Average monthly earnings for benefit purposes	Monthly benefit amount
A	1967	12	$400	$4,800	$386	$124
		12	500	4,800	386	124
		9	400	3,600	354	117
		9	500	4,500	377	122
		6	400	2,400	354	117
		6	500	3,000	354	117
		3	400	1,200	354	117
		3	500	1,500	354	117
B	1972	12	400	4,800	390	125
		12	500	4,800	390	125
		9	400	3,600	337	113
		9	500	4,500	376	122
		6	400	2,400	312	108
		6	500	3,000	325	111
		3	400	1,200	287	103
		3	500	1,500	293	104
C	1977	12	400	4,800	392	125
		12	500	4,800	392	125
		9	400	3,600	328	111
		9	500	4,500	376	122
		6	400	2,400	285	102
		6	500	3,000	307	107
		3	400	1,200	242	93
		3	500	1,500	253	95
D	1982	12	400	4,800	394	126
		12	500	4,800	394	126
		9	400	3,600	323	110
		9	500	4,500	375	121
		6	400	2,400	269	99
		6	500	3,000	296	105
		3	400	1,200	215	87
		3	500	1,500	228	90
E	1987	12	400	4,800	395	126
		12	500	4,800	395	126
		9	400	3,600	319	109
		9	500	4,500	375	121
		6	400	2,400	258	96
		6	500	3,000	288	103
		3	400	1,200	196	83
		3	500	1,500	212	87

II. A man earns maximum covered earnings in every year that he works under social security. He works in every year, 1951–62, inclusive. After 1962 and up to the year he reaches age 65 he works in covered employment intermittently. The following examples illustrate the effect of various work patterns on the worker's monthly benefit amount.

EXAMPLE NO. 1

After 1962 the man works 3 years and is out of covered employment the fourth year. This pattern of employment is continued up to the year he reaches age 65.

Worker	Attains age 65 in January	Average monthly earnings for benefit purposes	Monthly benefit amount
A	1967	$381	$123
B	1972	381	123
C	1977	380	123
D	1982	380	123
E	1987	367	120

EXAMPLE NO. 2

After 1962 the man works 2 years and is out of covered employment the following 2 years. This pattern of employment is continued up to the year he reaches age 65.

Worker	Attains age 65 in January	Average monthly earnings for benefit purposes	Monthly benefit amount
A	1967	$372	$121
B	1972	368	120
C	1977	352	117
D	1982	315	109
E	1987	290	103

EXAMPLE NO. 3

After 1962 the man works 1 year and is out of covered employment the following 3 years. This pattern of employment is continued up to the year he reaches age 65.

Worker	Attains age 65 in January	Average monthly earnings for benefit purposes	Monthly benefit amount
A	1967	$363	$119
B	1972	337	113
C	1977	276	100
D	1982	238	92
E	1987	212	87

APPENDIX C.—Federal Employment of Older Persons

TABLE 1.—*Distribution of paid Federal civilian employment, by selected agency and by age group, June 30, 1962*

Selected agency	Age group							
	Total	Less than 20	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and over
General Accounting Office	4,758	75	818	980	1,227	1,249	409	--------
Department of State	5,002	148	887	1,091	1,569	989	318	--------
Department of the Treasury	82,997	1,784	11,078	18,194	25,244	18,396	8,205	96
Department of Defense	996,030	15,726	121,455	259.348	340,315	191,561	65,912	1,713
Office of the Secretary of Defense and other defense activities	21,457	835	3,580	5,099	6,756	3,897	1,252	38
Department of the Army	356,338	6,914	44,391	92,589	118,794	69,567	23,468	615
Department of the Navy	331,480	4,591	35,108	77,435	118,710	69,625	25,421	590
Department of the Air Force	286,755	3,386	38,376	84,225	96,055	48,472	15,771	470
Department of Justice	17,971	454	2,130	4,155	5,901	3,957	1,327	47
Post Office Department	588,469	5,567	78,018	159,996	195,298	106,810	41,546	1,234
Department of the Interior	53,900	1,067	9,449	13,850	15,106	10,726	3,512	190
Department of Agriculture	110,045	2,575	19,390	27,580	29,850	23,435	7,041	174
Department of Commerce	31,124	732	6,391	7,561	8,257	6,122	2,025	36
Department of Labor	8,929	535	1,560	1,777	2,665	1,743	638	11
Department of Health, Education, and Welfare	73,161	3,298	16,699	17,640	20,160	12,298	2,961	105
Civil Service Commission	4,123	168	514	972	1,463	704	291	11
General Services Administration	31,518	305	2,351	5,887	9,828	8,260	4,789	98
Housing and Home Finance Agency	13,469	519	1,546	2,235	3,652	3,362	2,055	100
Information Agency	4,271	234	683	975	1,073	877	429	--------
Interstate Commerce Commission	2,442	74	222	518	827	530	271	--------
National Aeronautics and Space Administration	23,686	671	5,670	7,972	6,711	2,060	556	46
Veterans' Administration	176,234	1,445	22,301	44,575	59,235	34,828	13,540	310

NOTE.—These data have been drawn from a random sample of approximately 10 percent of the Federal work force and are therefore subject to sampling error. Excludes foreign nationals overseas, the Agency for International Development and the Peace Corps in the Department of State, the Federal Bureau of Investigation in the Department of Justice, the Alaska Railroad and the Geological Survey in the Department of the Interior, commissioned officers of the Coast and Geodetic Survey in the Department of Commerce, and the commissioned corps of the Public Health Service in the Department of Health, Education, and Welfare.

Source: U.S. Civil Service Commission.

TABLE 2.—*Percentage distribution of paid Federal civilian employment, by selected agency and by age group, June 30, 1962*

Selected agency	Age group							
	Total	Less than 20	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and over
General Accounting Office	100	1.58	17.19	20.60	25.79	26.25	8.60	----
Department of State	100	2.96	17.73	21.81	31.37	19.77	6.36	----
Department of the Treasury	100	2.15	13.35	21.92	30.42	22.16	9.86	0.12
Department of Defense	100	1.58	12.19	26.04	34.17	19.23	6.62	.17
Office of the Secretary of Defense and other defense activities	100	3.89	16.68	23.76	31.49	18.16	5.83	.18
Department of the Army	100	1.94	12.46	25.98	33.34	19.52	6.59	.17
Department of the Navy	100	1.39	10.59	23.36	35.81	21.00	7.67	.18
Department of the Air Force	100	1.18	13.38	29.37	33.50	16.90	5.50	.16
Department of Justice	100	2.53	11.85	23.12	32.84	22.02	7.38	.26
Post Office Department	100	.95	13.26	27.19	33.19	18.15	7.06	.21
Department of the Interior	100	1.98	17.53	25.70	28.03	19.90	6.52	.35
Department of Agriculture	100	2.34	17.62	25.06	27.13	21.30	6.40	.16
Department of Commerce	100	2.35	20.53	24.29	26.53	19.67	6.51	.12
Department of Labor	100	5.99	17.47	19.90	29.85	19.52	7.15	.12
Department of Health, Education, and Welfare	100	4.51	22.83	24.11	27.56	16.81	4.05	.14
Civil Service Commission	100	4.07	12.47	23.58	35.48	17.07	7.06	.27
General Services Administration	100	.97	7.46	18.68	31.18	26.21	15.19	.31
Housing and Home Finance Agency	100	3.85	11.48	16.59	27.11	24.96	15.26	.74
Information Agency	100	5.48	15.99	22.83	25.12	20.53	10.04	----
Interstate Commerce Commission	100	3.03	9.09	21.21	33.87	21.70	11.10	----
National Aeronautics and Space Administration	100	2.83	23.94	33.66	28.33	8.70	2.35	.19
Veterans' Administration	100	.82	12.65	25.29	33.61	19.76	7.68	.18

NOTE.—These data have been drawn from a random sample of approximately 10 percent of the Federal work force and are therefore subject to sampling error. Excludes foreign nationals overseas, the Agency for International Development and the Peace Corps in the Department of State, the Federal Bureau of Investigation in the Department of Justice, the Alaska Railroad and the Geological Survey in the Department of the Interior, commissioned officers of the Coast and Geodetic Survey in the Department of Commerce, and the commissioned corps of the Public Health Service in the Department of Health, Education, and Welfare. Percentages are rounded independently and not forced to add to totals.

Source: U.S. Civil Service Commission.

TABLE 3.—*Distribution of paid Federal civilian employees appointed since Jan. 1, 1959, by selected agency and by age group, June 30, 1962*

Selected agency	Age group							
	Total	Less than 20	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and over
General Accounting Office	840	75	506	151	22	75	11	----
Department of State	1,262	136	580	284	193	46	23	----
Department of the Treasury	22,125	1,731	8,365	6,089	3,963	1,742	203	32
Department of Defense	275,878	15,698	85,430	74,509	69,551	25,757	4,699	234
Office of the Secretary of Defense and other defense activities	8,274	797	2,353	1,898	2,062	999	152	13
Department of the Army	97,680	6,586	29,470	25,610	24,540	9,544	1,835	95
Department of the Navy	76,898	4,355	23,534	20,091	20,176	7,283	1,384	75
Department of the Air Force	93,026	3,960	30,073	26,910	22,773	7,931	1,328	51
Department of Justice	4,027	442	1,339	954	989	233	58	12
Post Office Department	160,542	5,342	55,867	50,771	35,228	10,963	2,253	118
Department of the Interior	18,619	1,034	7,181	4,969	3,513	1,477	378	67
Department of Agriculture	33,239	2,400	13,005	8,887	5,819	2,575	509	44
Department of Commerce	10,049	732	4,695	2,427	1,512	622	61	----
Department of Labor	3,360	501	1,241	706	718	149	34	11
Department of Health, Education, and Welfare	30,194	3,182	12,368	7,014	5,423	1,998	197	12
Civil Service Commission	1,117	168	413	301	134	67	34	----
General Services Administration	8,358	294	1,719	2,405	2,491	1,210	239	----
Housing and Home Finance Agency	4,849	519	1,207	1,038	1,197	718	140	30
Information Agency	1,170	234	429	312	156	20	19	----
Interstate Commerce Commission	654	74	173	160	210	37	----	----
National Aeronautics and Space Administration	9,234	625	3,749	2,812	1,655	324	46	23
Veterans' Administration	48,489	1,431	16,631	14,363	11,069	4,267	634	94

NOTE.—These data have been drawn from a random sample of approximately 10 percent of the Federal work force and are therefore subject to sampling error. Excludes foreign nationals overseas, the Agency for International Development and the Peace Corps in the Department of State, the Federal Bureau of Investigation in the Department of Justice, the Alaska Railroad and the Geological Survey in the Department of the Interior, commissioned officers of the Coast and Geodetic Survey in the Department of Commerce, and the commissioned corps of the Public Health Service in the Department of Health, Education, and Welfare.

Source: U.S. Civil Service Commission.

TABLE 4.—*Percentage distribution of paid Federal civilian employees appointed since Jan. 1, 1959, by selected agency and by age group, June 30, 1962*

Selected agency	Age group							
	Total	Less than 20	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 and over
General Accounting Office	100	8.93	60.24	17.98	2.62	8.93	1.31	----
Department of State	100	10.78	45.96	22.50	15.29	3.65	1.82	----
Department of the Treasury	100	7.82	37.81	27.52	17.91	7.87	.92	0.14
Department of Defense	100	5.69	30.97	27.01	25.21	9.34	1.70	.08
Office of the Secretary of Defense and other defense activities	100	9.63	28.44	22.94	24.92	12.07	1.84	.16
Department of the Army	100	6.74	30.17	26.22	25.12	9.77	1.88	.10
Department of the Navy	100	5.66	30.60	26.13	26.24	9.47	1.80	.10
Department of the Air Force	100	4.26	32.33	28.93	24.48	8.53	1.43	.05
Department of Justice	100	10.98	33.25	23.69	24.56	5.79	1.44	.30
Post Office Department	100	3.33	34.80	31.62	21.94	6.83	1.40	.07
Department of the Interior	100	5.55	38.57	26.69	18.87	7.93	2.03	.36
Department of Agriculture	100	7.22	39.13	26.74	17.51	7.73	1.53	.13
Department of Commerce	100	7.28	46.72	24.15	15.05	6.19	.61	----
Department of Labor	100	14.91	36.93	21.01	21.37	4.43	1.01	.33
Department of Health, Education, and Welfare	100	10.54	40.96	23.23	17.96	6.62	.65	.04
Civil Service Commission	100	15.04	36.97	26.93	12.00	6.00	3.04	----
General Services Administration	100	3.52	20.57	28.77	29.80	14.48	2.86	----
Housing and Home Finance Agency	100	10.70	24.89	21.41	24.69	14.81	2.88	.62
Information Agency	100	20.00	36.67	26.67	13.33	1.71	1.62	----
Interstate Commerce Commission	100	11.31	26.45	24.46	32.11	5.66	----	----
National Aeronautics and Space Administration	100	6.77	40.60	30.45	17.92	3.51	.50	.25
Veterans' Administration	100	2.95	34.30	29.62	22.83	8.80	1.31	.19

NOTE.—These data have been drawn from a random sample of approximately 10 percent of the Federal work force and are therefore subject to sampling error. Excludes foreign nationals overseas, the Agency for International Development and the Peace Corps in the Department of State, the Federal Bureau of Investigation in the Department of Justice, the Alaska Railroad and the Geological Survey in the Department of the Interior, commissioned officers of the Coast and Geodetic Survey in the Department of Commerce, and the commissioned corps of the Public Health Service in the Department of Health, Education, and Welfare. Percentages are rounded independently and not forced to add to totals.

Source: U.S. Civil Service Commission.

APPENDIX D

Low Incomes of the Aged: An Actual Fact or a Statistical Myth? [1]

It is only in recent years that the general public has been actively involved in debate over the interpretation of income statistics. Until a few years ago, the layman was careful not to fool around with statistics and statistical measures. He accepted as facts those that were presented to him in terms he could comprehend. Beyond that, he had respect for a science he didn't quite grasp.

Then, suddenly, the "battle of the income statistics" was launched and everybody got into the fray.

To see what can be done with the "numbers game," let's trace through the outstanding example.

SPECIAL PROBLEMS RELATED TO AGING

Our basic source of income data for the aged population—the U.S. Bureau of the Census—has consistently shown in recent years that more than half of all individuals aged 65 and over have cash incomes of less than $1,000 a year. This proportion was close to three-fifths only a few years ago but has dropped gradually to 53 percent in 1960. Other studies, provided they relate to the total noninstitutional aged population and are not distorted by one means or another, have confirmed these findings.

[1] An excerpt from "Income Problems of the Aged," a speech by Dorothy McCamman, a member of the professional staff of this committee, published in Aging in a Changing Society, a report on the Eleventh Annual Southern Conference on Gerontology, University of Florida Press, Gainesville, 1962.

TABLE 1.—*Estimated number of persons aged 65 and over in the United States*[1] *with money income from employment or public programs, June 1961*

Type of money income	Number (in thousands)			Percent of total		
	Total	Men	Women	Total	Men	Women
Total population aged 65 and over	17,130	7,760	9,370	100.0	100.0	100.0
Employment, total [2]	4,100	2,290	1,810	23.9	29.5	19.3
Employment and no income from public programs	910	630	280	5.3	8.1	3.0
Employment and social insurance benefits	2,610	1,230	1,380	15.2	15.9	14.7
Employment and payments under other public programs	580	430	150	3.4	5.5	1.6
Social insurance (retirement and survivor) benefits, total [3] [4]	12,430	5,940	6,490	72.6	76.5	69.3
Benefits and no earnings or veterans' or public assistance payments	7,950	3,660	4,290	46.4	47.2	45.8
Benefits and veterans' payments	1,090	710	380	6.4	9.1	4.1
Benefits and public assistance	780	340	440	4.6	4.4	4.7
Veterans' pension or compensation, total [4]	1,890	1,110	780	11.0	14.3	8.3
Veterans' payment and no earnings or social insurance [5]	310	30	280	1.8	0.4	3.0
Public assistance, total [6]	2,400	820	1,580	14.0	10.6	16.9
Public assistance and no earnings or payments under other public programs	1,510	420	1,090	8.8	5.4	11.6
No income from employment or public programs	1,390	310	1,080	8.1	4.0	11.5

[1] The 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.
[2] Includes 3,200,000 earners and an estimated 900,000 nonworking wives of earners (see table 2, footnote 2).
[3] Includes persons with income from 1 or more of the following sources: old-age, survivors, and disability insurance, railroad retirement, and government employee retirement (see table 2). Excludes person with benefits under unemployment or temporary disability insurance or workmen's compensation programs.
[4] Includes estimated number of beneficiaries' wives not in direct receipt of benefits.
[5] Includes a small number receiving supplementary public assistance.
[6] Old-age assistance recipients and persons aged 65 and over receiving aid to the blind or to the permanently and totally disabled, including a relatively small number receiving vendor payments for medical care but no direct cash payment under either old-age assistance or medical assistance for the aged.

TABLE 2.—*Total money income of families with head aged 65 and over and head under 65, by size of family, 1960*

[Noninstitutional population of the United States]

Characteristic	All families	Families containing—			
		2 persons	3 persons	4 persons	5 or more persons
Median money income of family:					
Head 65 and over	$2,897	$2,530	$4,122	$6,100	$5,727
Head under 65	5,905	5,314	5,930	6,300	6,074
Percent of families with income of—					
Under $2,000:					
Head 65 and over	31.4	35.7	20.3	17.6	17.9
Head under 65	10.2	16.0	9.0	6.5	8.9
$7,000 and over:					
Head 65 and over	16.4	11.5	23.5	41.4	37.9
Head under 65	37.1	31.1	37.8	41.0	38.8
Percentage distribution by size:					
Head 65 and over	100.0	72.9	16.4	5.1	5.6
Head under 65	100.0	26.4	21.6	22.9	29.1
Average (mean) size:					
Head 65 and over	2.5	2.0	3.0	4.0	6.4
Head under 65	3.9	2.0	3.0	4.0	6.2

Source: Bureau of the Census "Current Population Reports, Consumer Income," series P–60, No. 37.

These data on the incomes of individuals have this long-recognized drawback—they include, among the persons having "zero" income, married women who are entirely supported by their husbands, accounting in part for the fact that fewer than 4 percent of all aged men but as many as 24 percent of the women had no income in 1960. It has also long been recognized by those who work closely with these figures that the proportion of the aged population with incomes of less than $1,000 would remain about the same if half the husband's income were allocated to his wife, thus improving the position of the women but bringing some additional men into the group with less than $1,000.

In assessing the income situation of the aged, heavy reliance has necessarily been placed on this measure of the proportion of aged persons with incomes of less than $1,000. The alternative would have been to use Census Bureau data on the incomes of families with an aged head. Here, there is an even more serious drawback. Family income data are difficult to interpret, both because the family members may not form a meaningful economic unit and because the designation of a person as head of a family in joint households may be quite arbitrary. The income total for a family classified as having a head over 65 may therefore include substantial amounts of income received by adult children and other family members. Moreover, aged persons who are not classified as family heads—and these are the very persons who are likely to have the smallest incomes—are in effect "lost" in such an analysis.

Against this background, we return to the example of what you can do with the "numbers game."

Several years ago, an article in the Journal of the American Medical Association attacked the Census Bureau data on the proportion of the aged with incomes below $1,000, as follows:

> The important fact to be remembered is that the money income figures cited by the Department of Health, Education, and Welfare and others refer to individual and not to family income. In other words, let us imagine that a club is composed of a number of persons and their respective husbands or wives and that the conditions of membership in the club are (1) that only one member of each family be an income earner, and (2) that the average income per family be in excess of $20,000 per year. This is the club. By using the same statistical technique or formulation as that employed by the Department of Health, Education, and Welfare, one-half (50 percent) of the members of that club have incomes of less than $1,000 per year (zero incomes, in fact) and, so long as the same conditions exist, will continue to have zero incomes even though the average income per person for the club has to be, by the very conditions of membership, in excess of $10,000 a year.[2]

[2] Arthur Kemp, Leonard W. Martin, and Cynthia Harkness, "Some Observations on Financial Assets of the Aged and Forand-Type Legislation," Journal of the American Medical Association, 171: 1229, Oct. 31, 1959.

TABLE 3.—*Percentage distribution of persons aged 65 and over, by total money income, and by sex, 1960*

[Noninstitutional population of the United States]

Money income class	Total[1]	Men	Women
Total	100.0	100.0	100.0
Less than $1,000	52.7	27.1	73.9
Zero	14.5	3.6	23.6
$1 to $499	11.7	5.5	16.8
$500 to $999	26.5	18.0	33.5
$1,000 to $1,999	23.7	32.0	16.8
$1,000 to $1,499	15.3	20.1	11.2
$1,500 to $1,999	8.4	11.9	5.6
$2,000 to $2,999	10.2	17.3	4.5
$3,000 to 4,999	7.2	11.8	3.4
$5,000 or more	6.3	11.8	1.7
Median income, all persons	$950	$1,620	$640
Income recipients	1,150	1,700	820
Year-round, full-time workers	(2)	4,120	2,840

Source. Distributions for men and women derived from Bureau of the Census, "Current Population Reports, Consumer Income," series P–60, Nos. 36 and 37.

[1] The distributions for men and women were combined using population figures estimated in the Division of Program Research by updating the decennial census counts after adjustment to exclude institutional inmates (estimated at 540,000). The Bureau of the Census has not yet released estimates for aged persons in the noninstitutional population as of the spring of 1961, when the income data were collected.

[2] Not available.

Thereafter, the same line of attack has been used repeatedly, but with the example personalized. There have been countless times when I have heard—and I am sure you have also heard—a doctor, an insurance company officer, or some other high-level executive refer disparagingly to these figures in the following vein: "I happen to have a very good income. I have a wife and three children (or four, or five) and they have no income of their own. Thus, four out of five of us (or five out of six or six out of seven) have less than $1,000 in income. But that doesn't really mean that my wife and children are badly off. We do very well as a family."

True enough. But there is a drastic difference between his situation and that of an aged person. The layman who hears this line of reasoning may feel that there is something wrong with the analogy, but since he can't quite put his finger on it he is persuaded by the arithmetic.

It takes a relatively sophisticated person to recognize that one significance attaches to the fact that young wives and children who are normally dependent on the breadwinner's earnings have little or no income of their own. Quite another significance attaches to the high proportion of the aged with little or no income; here it must be recognized that the older group is heavily weighted by widows, wives of retired men, and other aged women who are no longer supported by earnings and, therefore, might be expected to have some income of their own in the form of a widow's or wife's social security benefit, for example, or from private sources.

More recently, I have seen these same Census Bureau figures attacked in another way. The attack centered on the upper end of the income distribution—the "open" end where "all the millionaires" are found. The implication of this argument was that we needn't worry

about the women with less than $1,000 in income because the men at the upper end of the income scale had unlimited incomes with which to support them.

The usual distribution of the incomes of the aged starts this "open" end at $5,000. This would mean that in 1960 there were 6⅔ million women with incomes of less than $1,000 to be supported by fewer than 900,000 men with incomes of $5,000 or more, or 7½ women for every man. Even if we were to assign to the low-income women all the men with incomes of $2,000 or more, the 6⅔ million women would be feeding on a paltry 3 million men, less than half a man apiece.

It would be nice to think that newly available Census Bureau data on the incomes of the aged would put an end to this kind of nonsense, really settling the battle of the income statistics once and for all.

For the first time, the Census Bureau data are presented by major social and economic characteristics, permitting a comparison of the incomes of older and younger families of equal size. It is now possible to single out the two-person family headed by a person over 65 and, because such families are usually married couples, thereby greatly reduce the chance that income will include earnings of younger family members. Of all families with an aged head, nearly three-fourths consist of only two persons. Their median income in 1960 was $2,530, less than half that for two-person families with a head under 65 ($5,314).

Among unrelated individuals (persons living alone or lodging with nonrelatives) the economic disadvantage of the aged compared with the young is even more marked. The median income in 1960 reported by such persons aged 65 and over was only about 40 percent as large as for those under 65—$1,050, compared with $2,570.

The aged are a low-income group and it is high time to stop juggling figures in the attempt to prove otherwise.

APPENDIX E

UNIVERSITY OF MICHIGAN NEWS SERVICE RELEASE, ANN ARBOR

ANN ARBOR.—New and detailed data on the economic condition of the aged have been collected in the 1962 Survey of Consumer Finances, conducted by the Survey Research Center (SRC) of the University of Michigan.

In view of current interest in the subject, the center has reported some comparisons between the financial situation of younger groups and that of spending units whose heads are 65 years of age or older in advance of the publication of the 1962 survey.

Among the older units (65 and over), 71 percent had a disposable income of less than $3,000 and 10 percent had more than $5,000 in 1961. (In the 55–64 year group, figures were 34 and 38 percent, respectively).

Not only do older units have substantially lower incomes than younger ones, but low incomes are commonly temporary among younger families and permanent among the aged. On the other hand, the number of persons included in a spending unit (families or individuals) decreases with age; therefore, the age differences in per capita income are smaller than in spending unit incomes.

Average income reaches its peak among those in their forties and declines slowly among those in their fifties and rapidly among people over 65. Average assets are highest in the 55–64 year age group and decline slightly among those over 65. Financial reserves are gradually accumulated over many years, and spending unit net worth also increases with age because of the gradual repayment of mortgage debt on the part of homeowners.

The distribution of assets among the spending units 65 years and over is much more unequal than among younger units. The average asset data are greatly influenced by the small proportion of aged with sizable asset holdings. While the average assets of those 65 and older are similar to those 55 to 64 years old, 34 percent of the former have practically no liquid assets at all (less than $100 in bank deposits and bonds) as against 28 percent of the latter. Net worth data, including homeownership and investments and deducting debt, show that 23 percent of those 65 and over have net worth under $1,000 as against 14 percent in the 55 to 64 years group.

Consumer debt is less common among the aged than among middle-aged or young people because the latter are much more frequent purchasers of automobiles and appliances.

Forty-three percent of spending units over 65 reported having had what they called large medical expenses for doctors, nurses, and hospitals in 1961 against 36 percent in the 55–64 age group and 39 percent among all those between 35 and 64.

These data consider only aged people with some income who form independent spending units. In addition, there are about 2 million aged individuals excluded from the tabulation because they have no income and form a part of the spending units of their children or other relatives. Many other older people are excluded because they live in institutions.

Altogether there are approximately 9½ million spending units in which the head is 65 years of age or older. A large proportion of the heads are widowed so that altogether heads and wives represent 14½ million people. Among these older spending units, those with relatively high income tend to have sizable assets, while those with low income tend to have small assets. It appears that there are close to 4.5 million spending units 65 and older who had a 1961 disposable income of less than $2,000 (including social security benefits). Forty percent of these units have practically no assets, and most of them have no medical insurance either.

Distribution of income and assets by age (percentage distribution of spending units)

	Age of head of spending unit			
	35 to 44	45 to 54	55 to 64	65 and over
Disposable income in 1961: [1]				
Under $3,000	14	22	34	71
$3,000 to $4,999	25	21	28	19
$5,000 to $7,499	33	27	22	4
$7,500 and over	28	30	16	6
Total	100	100	100	100
Liquid asset holdings early in 1962: [2]				
Under $100	36	31	28	34
$100 to $999	36	28	20	14
$1,000 to $4,999	22	26	36	27
$5,000 and over	6	15	16	25
Total	100	100	100	100
Net worth early in 1962: [3]				
Under $1,000	26	19	14	23
$1,000 to $4,999	21	15	17	14
$5,000 to $24,999	39	41	47	44
$25,000 and over	14	25	22	19
Total	100	100	100	100

[1] Spending unit annual income minus Federal income taxes.
[2] Deposits with banks, savings and loan associations, and credit unions, and U.S. Government savings bonds.
[3] Liquid assets plus investments in stocks and bonds, farm, livestock and equipment, other real estate, business, plus equity in owner-occupied home, minus debt. The most frequent assets are liquid assets and homeownership.

APPENDIX F

Tax Provisions Favoring Older Persons [1]

The laws and regulations governing the Treasury's collection of tax revenues contain a number of provisions which grant preferential treatment to older persons or to members of their family who are responsible for their support. For the fiscal year 1962, it is estimated that three of these special provisions (the double exemption, the retirement-income credit, and the more liberal treatment of medical expenses of the aged) resulted in tax savings for older persons of $742 million.

Data from income tax returns filed for 1959 (the latest year for which such data are available) indicate that of the approximately 15.5 million persons 65 and over in that year, 6.7 million persons were accounted for on the 5.2 million returns filed by taxpayers aged 65 or over, but only 3.3 million persons had taxable returns.

Persons 65 or over do not have to file an income tax return unless their income exceeds $1,200, as compared with the $600 filing requirement for other taxpayers. They are allowed double personal exemptions amounting to $1,200.

Thus, a husband and wife who are 65 or older are allowed an exemption of $2,400. This exemption, together with the 10 percent standard deduction, means that they may have income of up to $2,675 without paying any tax.

Older people who are blind may get further relief from the additional personal exemption of $600 which is allowed to blind people. On income tax returns filed for 1959, approximately 6.7 million additional exemptions were claimed for age. Social security and railroad retirement benefits are exempt form tax. Under the retirement-income credit provision, retired persons 65 or over who get modest amounts in pensions, annuities, interest, dividends, and rents may be completely exempt from tax.

Under the credit provision, the first $1,200 of retirement income is exempt from the first bracket rate of 20 percent. This means a tax saving of up to $240 a year, or up to $480 if husband and wife both qualify. A husband and wife both of whom are 65 or over and qualify for the retirement income credit may receive as much as $5,333 without paying any tax. In 1959, a tax credit for retirement income was claimed on more than 748,00 returns and a total tax reduction of more than $111 million was claimed on the basis of this credit.

The table on page 223 further illustrates the tax benefits accruing to older persons as a result of the double exemption, the exclusion of social security and railroad retirement benefits, and the retirement-income credit. It also shows the combined effect of the "dividends

[1] How the Government Works for Older People, 1962 Report to the President of the Federal Council on Aging, pp. 87–92.

received" exclusion and credit (which is available to all taxpayers) and the retirement-income credit.

It indicates, for example, that a single person under 65 receiving wages of $2,164 pays $269 in income tax, while a single person aged 65 or over receiving the same amount of income pays no tax if his income consists of the average social security benefit, a small amount of other retirement income, and the maximum amount of earnings permitted without a reduction in his social security benefits.

A married couple both under 65, with wage income of $5,168 pays a tax of $690, while a married couple both 65 or over receiving this same amount of income pays no tax if their income consists of the average social security benefit, the maximum amount of earnings permitted without a reduction in social security, and other retirement income.

A married couple both over 65 and qualifying for the dividend exclusion and credit and the retirement-income credit may receive $6,100 free of tax, while a young married couple with a salary of $6,100 would pay a tax of $864.

As a result of special tax provisions, older persons are able to deduct a considerably greater portion of their medical expenses than younger persons. They may deduct medical expenses without being limited like younger people to deducting only those expenses in excess of 3 percent of adjusted gross income.

All taxpayers who incur medical expenses on behalf of their aged, dependent parents may deduct such expenses without regard to the 3-percent limitation. Even though the parent is not eligible for a dependency exemption (because he has income of $600 or more) the taxpayer may deduct the medical expenses paid for him, if he contributes the chief support of the parent.

Individuals 65 or over are subject to the 1-percent drug limitation and to the maximum dollar limitation on the medical expense deduction, but a special provision adopted in 1958 raised the maximum limitation on the amount of medical expenses which can be deducted by elderly persons who are so disabled that they are unable to work.

If a taxpayer or his spouse has reached 65 and is disabled, he may deduct up to $15,000 of medical expenses instead of the $5,000 maximum allowed generally in the case of a single taxpayer or a married person filing a separate return. If both the taxpayer and his spouse are disabled and 65 or older, the limitation on a joint return is $30,000 as compared with the $10,000 allowed generally for a joint return.

In 1958, the latest year for which data are available, persons 65 or over who itemized their medical expenses were able to deduct $900.9 million, or 97 percent of their total medical expenses (exclusive of drug costs disallowed by the 1-percent limitation). For taxpayers in the age group under 65 (who can deduct only the medical expenses in excess of 3 percent of adjusted gross income) less than 65 percent of their total medical expenses were eligible for deduction.

The tax laws also contain several provisions which encourage the growth of nondiscriminatory pension plans enabling individuals to meet retirement needs. Employers are allowed, within certain limits, to deduct contributions to such plans; covered employees are permitted to postpone payment of tax on the employer's contribution until they receive the benefits; and qualified trusts established to administer the pension plans are exempt from tax.

Comparison of tax liability of individuals age 65 or over and individuals under 65 with equal amounts of income from different sources

Wages	Retirement income (other than dividends) [1]	Dividend income	Social security benefit	Railroad retirement benefit	Total income	Adjusted gross income	Tax liability [2]
SINGLE PERSON, AGE 65 OR OVER							
$1,324					$1,324	$1,324	
	$2,674				2,674	2,674	0
		$3,049			3,049	2,999	0
1,200	124		[3] $840		2,164	1,324	0
	1,724		[3] 840		2,564	1,724	0
1,200	124		[4] 1,452		2,776	1,324	0
	1,324			[5] $1,512	2,836	1,324	0
	1,324			[6] 2,500	3,824	1,324	0
SINGLE PERSON, UNDER 65							
$1,324					$1,324	$1,324	$116
2,674					2,674	2,674	359
		$3,049			3,049	2,999	336
2,164					2,164	2,164	269
2,564					2,564	2,564	341
2,776					2,776	2,776	382
2,836					2,836	2,836	391
3,824					3,824	3,824	585
MARRIED COUPLE, BOTH 65 OR OVER							
$2,674					$2,674	$2,674	0
	$5,333				5,333	5,333	0
		[7] $6,100			6,100	6,000	0
1,200	2,460		[3] $1,488		5,168	3,680	0
1,200	1,999		[4] 2,178		5,377	3,199	0
	3,199			[5] $2,448	5,647	3,199	0
2,674				[6] 3,339	6,013	2,674	0
MARRIED COUPLE, BOTH UNDER 65							
$2,674					$2,674	$2,674	$239
5,333					5,333	5,333	720
		$6,100			6,100	6,000	676
6,100					6,100	6,100	864
5,168					5,168	5,168	690
5,377					5,377	5,377	728
5,647					5,647	5,647	776
6,013					6,013	6,013	847

[1] For married couples, assumes that $1,200 belongs to wife and remainder to husband.
[2] Tax liability as determined by tax table where applicable.
[3] The average monthly benefit amounts at the end of 1960 were: For a retired worker, $70; for a retired worker and aged wife, $124; for married couples, ½ of benefit belongs to wife.
[4] Maximum old-age benefit possible except under rare conditions. For married couples, ½ of benefit belongs to wife.
[5] Average railroad retirement benefit, December 1961. For married couples, $708 belongs to wife.
[6] Maximum railroad retirement benefit. For married couples $839 belongs to wife.
[7] Assumes that both husband and wife qualify for the dividend exclusion and credit and the retirement income credit.

In 1960 employers contributed $4.5 billion on behalf of 21.6 million employees covered under such private pension and deferred profit-sharing plans while approximately 1.8 million beneficiaries of these plans received almost $1.7 billion in benefits. In the same year, Federal, State, and local government retirement systems paid retirement benefits of $1.7 billion to approximately 887,000 beneficiaries.

To provide pensions for workers retiring in the future, over $79.6 billion had been accumulated by the end of 1960 in these private and public pension funds (exclusive of OASDI and railroad retirement funds). In the case of the private pension funds, both the existence of the plans and the size of the individual pension payments have been significantly affected by favorable tax treatment.

Older persons may also benefit from the provision which allows a special exclusion of up to $5,000 for death benefits paid by an employer to the beneficiaries of a deceased employee. Moreover, many older citizens benefit from a provision which exempts from tax wage-continuation payments up to a maximum weekly rate of $100 received by employees under an employer-finance plan which pays them during absence from work because of injury or illness.

Older persons who are widows or widowers or who are not married may benefit from the special tax rate provided for a head of household if they share their home with an unmarried child, grandchild, or stepchild or with any other dependent relative.

A taxpayer who supports his dependent father or mother may qualify as head of household even though his parents continue to live in their own home. Another measure of assistance to taxpayers with elderly dependents is the provision allowing employed women and widowers to deduct up to $600 a year of expenses for the care of disabled dependents.

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