EVALUATION OF ADMINISTRATION ON AGING AND CONDUCT OF WHITE HOUSE CONFERENCE ON AGING

HEARINGS

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST SESSION

PART 7—DES MOINES, IOWA

MAY 13, 1971

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

60-215 WASHINGTON : 1971

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 35 cents

SPECIAL COMMITTEE ON AGING

FRANK CHURCH, Idaho, *Chairman*

HARRISON A. WILLIAMS, JR., New Jersey
ALAN BIBLE, Nevada
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri

WINSTON PROUTY, Vermont
HIRAM L. FONG, Hawaii
JACK MILLER, Iowa
CLIFFORD P. HANSEN, Wyoming
PAUL J. FANNIN, Arizona
EDWARD J. GURNEY, Florida
WILLIAM B. SAXBE, Ohio
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois

WILLIAM E. ORIOL, *Staff Director*
DAVID A. AFFELDT, *Counsel*
JOHN GUY MILLER, *Minority Staff Director*

Part 1. Washington, D.C., March 25, 1971
Part 2. Washington, D.C., March 29, 1971
Part 3. Washington, D.C., March 30, 1971
Part 4. Washington, D.C., March 31, 1971
Part 5. Washington, D.C., April 27, 1971
Part 6. Orlando, Fla., May 10, 1971
Part 7. Des Moines, Iowa, May 13, 1971
Part 8. Boise, Idaho, May 28, 1971
Part 9. Casper, Wyo., August 13, 1971

CONTENTS

EVALUATION OF ADMINISTRATION ON AGING AND CONDUCT OF WHITE HOUSE CONFERENCE ON AGING

THURSDAY, MAY 13, 1971

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Des Moines, Iowa.

The committee met, pursuant to call, at 2 p.m., in Veterans Memorial Auditorium, Senator Jack Miller of Iowa, presiding.

Present: Senator Miller.

Also present: John Guy Miller, minority staff director; Ken Dameron, professional staff member; Peggy Fecik, assistant chief clerk; and Donna Colombo, clerk.

OPENING STATEMENT OF SENATOR MILLER, PRESIDING

Senator MILLER. The committee will come to order, please.

First of all, I would like to welcome the witnesses and many other interested persons this afternoon to this official hearing of the U.S. Senate Special Committee on Aging.

The last time we held a similar hearing in Iowa was in September of 1969, and I am advised that copies of the hearing report at that time are available in the back of the room and that further copies of this have been made available to each of you in your kits.

I should advise that a record of all testimony presented today will be made a part of the record of the Senate and distributed to Members of the Senate for their information. Individuals who are desirous of doing so may request copies of the hearing proceedings by writing to the Special Committee on Aging, Washington, D.C.

There are nine scheduled witnesses for today's hearing. After completion of their testimony, an opportunity will be given, as long as time permits, to receive comments from members of the audience and, if desired, to put questions to the panel of witnesses. There is only one floor microphone right up here by the stage. If you wouldn't mind coming forward and taking your turn to use the microphone, I think it would be helpful so everyone can hear your questions or comments.

These witnesses, I understand, have headed up the Iowa White House Conference on Aging task forces. I should state that copies of the task force reports have been made available to our committee and will be incorporated into the record.[1]

Any person whom we are not able to hear and who has a comment or observation he or she would like to make, may write out a state-

[1] See appendix 1, p. 445.

ment on the forms we have prepared for this purpose. They are rather simple forms and I understand they are in the back of the room. Mail them to me at my office in the New Senate Office Building in Washington. They will be made a part of the proceedings of this hearing.[2] The record will be kept open for 30 days for this purpose.

This hearing is concerned with the 1971 White House Conference on Aging called by President Nixon and scheduled to convene in Washington during the week beginning on Suday, November 28, 1971. This hearing is part of the continuing search by our committee for practical and realistic approaches to the unresolved needs of our senior citizens.

It is the committee's wish to have a review of the situation of our senior citizens in Iowa because their problems encompass both rural and urban areas, and, further, the State of Iowa, I am very proud to say, has shown considerable leadership in the field of geriatrics. Accordingly, this hearing was scheduled in conjunction with your Iowa State Conference on Aging.

Other committee hearings are being held in conjunction with State conferences on aging in other States. As such, they are a continuation of a series on the Evaluation of Administration on Aging and Conduct of White House Conference on Aging, which began with hearings in the Nation's Capitol in March of this year.

Review of Earlier Hearings

I might say at this point for those of you who are not familiar with what has happened that there was some disappointment over the way the budget came out early this year with respect to various programs pertaining to the Administration on Aging. I am pleased to say that on April 27 some changes in the budget were announced and the result is this, that for the foster grandparents program the amount appropriated for fiscal year 1971, which will soon end, was $10.5 million, and the amount now in the budget request is $10.5 million. For community grants, title III, the amount for fiscal year 1971 was $9 million, and the amount in the revised budget request is $9 million. The amount for areawide projects was $2.2 million for fiscal 1971, and that has been increased in the budget to $5.2 million.

The amount for State planning grants for fiscal 1971 was $4 million and the amount requested in the revised budget is $4 million. The amount for retired senior volunteer program, the RSVP program, was $0.5 million for fiscal 1971, and the amount requested in the revised budget is $5 million.

The amount for research grants for fiscal 1971 was $2.8 million, and the amount of the revised budget request is $2.8 million.

Finally, the amount for training grants was $3 million for fiscal year 1971, and the amount of the revised budget is $3 million.

So there is a total of $32 million for fiscal 1971, and it is now $39.5 million in the revised budget request.

I might say there were several of us, including myself, who made some rather strenuous efforts to get the budget revised and we feel very pleased that it has been revised.

It is imperative that the more than 350,000 Iowans past 65 and the some 20 million other Americans in this age bracket be made aware that

[2] See appendix 2, p. 487.

our national policy is not to forget them, but to reward them with a better life for the contributions they have made over their lifetime. For these, and for those who will some day reach this age, it must be clearly demonstrated we intend to move as quickly as possible to meet the challenges posed by that national policy.

The challenge to Congress and also to the State legislatures is to legislate programs that are both imaginative and effective, and this means calling on both the resources of the public and the private sectors, with the private sectors as the senior partner.

In the past we have not always legislated on the premise that Government must meet a need measured by the shortcomings in an enlightened private sector. Too frequently we have forgotten that mistakes as well as oversights on the part of Government resulted in social hardships, sometimes with great and unbearable hardships.

Since 1960 the 65-and-older generation has increased some 21 percent and now constitutes nearly 10 percent of the total population, virtually one in every 10 persons in this Nation. And there has been a proportionate increase in the problems associated with this age group, problems that demand attention and require understanding of every American, young and old alike.

We know that a substantial number of our senior citizens must stretch their savings, pensions, and other income painfully thin in order to cope with problems of health, the cost of living, housing, and transportation. We also know that meaningful retirement years are still denied millions of older Americans.

It is our purpose in the Congress to develop comprehensive programs that will get at the root of these problems and enrich the lives of our senior citizens. Moreover, our senior citizens, as a group, are one of our Nation's human resources which is not being turned to full advantage of our society. Programs should be directed toward doing something about this.

White House Conference National Study

A recent national survey sponsored by the White House Conference on Aging covered 200,000 Americans age 55 and older:

More than half who filled out the questionnaire about their needs said they didn't have enough money to make ends meet;

Fifty-five percent said they could not afford to buy the food they like;

More than half said that to get by they must spend less than $200 a month and 20 percent said they are limited to less than $100 a month;

Twenty-five percent said they had health problems that are not getting attention;

One-third reported transportation problems and one-fifth cited lack of adequate transportation;

A discouraging 17 percent responded with a "yes" to the question, "Do you sometimes feel that you have nothing to live for";

And another 22 percent said they "sometimes feel they are just not wanted".

This committee, the White House Conference on Aging, the Congress, and the legislatures, and, indeed, all Americans, should make

sure that these people do have something to live for and do feel they are wanted.

But it is no small task, for we must also determine:

How best to balance our resources to meet the needs of older Americans as well as to meet the needs of other segments of our population;

What the priorities should be for action, recognizing that our resources are limited;

What should be the specific roles of the Federal, State, and local government units and the private sectors in responding to the needs of our senior citizens;

How do we make an adequate evaluation of the services and programs for our aging population.

With that, I will call the first witness, who is G. David Hurd of Des Moines, vice president of Bankers Life Co.

Mr. Hurd.

STATEMENT OF G. DAVID HURD, DES MOINES, VICE PRESIDENT, BANKERS LIFE CO.

Mr. HURD. Thank you, Senator Miller.

I would like to comment very briefly that the preconference task force report, which was prepared and used as a base for today's discussions, and the resolutions that were adopted in our workshop efforts this morning showed both a philosophical concern for long-range goals and very specific concern for particular short- and long-term changes that are needed.

I think, as has already been indicated in Senator Miller's remarks, that it was relatively easy for both the task force and this morning's workshop to come to grips with the primary problem in the needs in the income area. Simply stated, the poor aged do not have enough income, they need more, and the prime recommendations of both the task force and the workshop bear on this point.

For example, the task force had recommended that without exception every American, older American, should be entitled to an income level of at least $1,500 for a single person or $2,000 for a couple.

In this morning's workshop efforts a resolution was adopted asking that a national minimum income level be established with $2,000 for a single person and $4,000 for a couple. This is in the broad terms that I referred to.

As an example of some of the more specific items that were dealt with, a resolution was adopted that under the present Social Security system the earnings deduction, or whatever proper phraseology would be, between ages 65 and 70 be eliminated so that a person could have earned income without reducing their social security. I think the sense of these are all keyed to the idea of inadequate income and striving for ways to reach that adequacy.

Other areas that were dealt with related to such things as reductions in old age assistance when Social Security is increased and the need to change that factor and various ways of strengthening private pension programs.

I felt from this morning's efforts that we had a group of seriously concerned individuals present who were striving straightforwardly

to get to the heart of the matter and try to come up with some good recommendations.

We now have typed copies of this morning's resolutions, the preconference task force, and a summary comment [1] to turn in for the hearing record.

I thank you.

Senator MILLER. Thank you, Mr. Hurd.

SOCIAL SECURITY AS INCOME FOR TAX PURPOSES

May I ask you a question. I note from the summary of the recommendations in the statement of the task force that payments of these—I assume you are referring to Social Security payments—that payments would be treated as ordinary income for income tax purposes by all beneficiaries, is that correct?

Mr. HURD. Yes, Senator. The basic thought that was behind that and behind a resolution that was adopted in this morning's workshop was that for aged persons who do happen to have rather substantial income, it would be fair for part of their income to go to help support benefits for folks who had very little. This, I think, is the sense of the resolutions and statements.

Senator MILLER. We crossed that bridge in the Tax Reform Act of 1969. You may recall there had been some recommendations on that point. I think many of the Members of Congress were a little gun-shy on it because there was a popular misconception on the part of many people that even the relatively poor and low-income individuals would have to be paying some income tax on their Social Security. The Tax Reform Act of 1969, I believe, did a pretty good job of eliminating the income tax on these low-income individuals.

Would it be your assessment that if we did change the law to require the inclusion of Social Security income in income for income tax purposes that the lower, certainly, and the nonincome people other than social security would not have any tax to pay?

Mr. HURD. That is our understanding and the base from which these recommendations were adopted.

Senator MILLER. That is my understanding. In view of what we did in the Tax Reform Act of 1969, I am not so sure it would have happened without the changes we made in that act, but with the changes we made in that act plus the double exemption for people 65 and older, I think we could probably assure the people that no one in the lower and nonincome tax brackets other than social security would be paying any income tax on Social Security, but those who have substantial income would, indeed, have to pay some income tax on it. Is that correct?

Mr. HURD. Yes; Senator.

Senator MILLER. Thank you, Mr. Hurd.

Our next witness is Dr. Woodrow W. Morris, whom many of you know, from Iowa City, vice chairman, Commission on the Aging, State of Iowa; associate dean, College of Medicine, and director, Institute of Gerontology, University of Iowa.

It is good to see you again, Dr. Morris.

[1] See appendix 1, p. 445.

STATEMENT OF DR. WOODROW W. MORRIS, IOWA CITY, VICE CHAIRMAN, COMMISSION ON THE AGING, STATE OF IOWA; ASSOCIATE DEAN, COLLEGE OF MEDICINE, AND DIRECTOR, INSTITUTE OF GERONTOLOGY, UNIVERSITY OF IOWA

Dr. MORRIS. Thank you, Senator. It is good to see you back home.

We are especially glad to see you today on this particular occasion, the occasion of our State-White House Conference on Aging. We are particularly grateful to you for the fine work you are doing on this Senate committee, Special Committee on Aging, and for the deep concern you have for the elderly citizens of Iowa and the whole Nation.

I believe you have received a copy of the report of the task force on health entitled "Toward a Healthier Future for the Elderly of Iowa," and I request this report[1] be made a part of the official records of these hearings, if that is possible.

Senator MILLER. It will be, Dr. Morris.

Dr. MORRIS. Thank you.

The task force on health was given a specific charge and that charge is included in the report and I would briefly like to touch upon the main areas covered in the charge because the recommendations made by the task force and adopted by the hearings this morning are directly related to the charge the task force was given.

These included six points:

1. To examine and evaluate the extent to which elderly Iowans are receiving the health care they need, and in this was a broad inclusion of all senses of health care;
2. To examine and evaluate the effectiveness of such fiscal mechanism as Medicare and Medicaid and insurance programs;
3. To include an emphasis upon prevention and rehabilitation;
4. To examine and evaluate the availability and effectiveness of mental health care services for the elderly in Iowa;
5. To determine the extent to which treatment of emotional disturbances is available to older Iowans; and
6. To evaluate the situation with respect to continuing research into the health care needs and possible programs to meet those needs of the elderly of this State.

The task force itself produced 16 recommendations. At the hearings this morning these recommendations were all adopted with one exception. Recommendation No. 4 in the original report was rewritten this morning and a substituted recommendation was adopted.

TOP PRIORITY RECOMMENDATIONS

The group this morning, at the end of the hearing, selected three of the 16 recommendations as having top priority, and they are as follows:

Recommendation No. 3 was given a top billing. It states that:

It is recommended that the State Health Department Health Facilities Service be charged to determine the optimum needs for all types of health care facilities for all areas of the State and based upon such a determination of needs a State Master Plan be developed which will assure adequate numbers of beds of all types for all areas of the State. It is further recommended that whatever legis-

[1] See appendix 1, p. 448.

lative authority is required be enacted along with appropriations of sufficient funds to assure the development, evaluation, and implementation of such a State Master Plan at the earliest possible moment.

Recommendation No. 4 was rated next. It is the one I mentioned that was rewritten. In its new form it states:

It is recommended that the necessary steps be taken immediately to assure Iowa's aged and medically indigent population full Medicare and Medicaid benefits as prescribed by the patient's attending physician subject only to local providers' utilization review committee.

Recommendation No. 6 was rated third in importance, and it states:

That it is recommended that an interdepartmental coordinating body comprising representatives of the State bodies of health, social services, and the Commission on Aging be formed and given adequate financing and authority to promote, develop, and establish comprehensive home health care programs in each section of the State. This should include developing adequate training programs for personnel who will staff such programs.

Recommendations 9 and 10 were concerned with preventive medicine and rehabilitation, and recommendation 11 was a series of six concerning mental health. These three together were given next highest priority. Because they are all in the original report, I will not read them.

Finally, I would like to point out that the task force reviewed and adopted in toto all of the health recommendations contained in the report of the President's Task Force on the Aging entitled "Toward a Brighter Future for the Elderly."

Thank you, sir.

Senator MILLER. Thank you, Dr. Morris.

You mentioned a recommendation which went like this, that the necessary steps are taken immediately to assure Iowa's aged and medically indigent populations full Medicare and Medicaid benefits as prescribed by the patient's attending physician subject only to the local providers' utilization review committee. Will you tell us what the implications are of that recommendation?

Dr. MORRIS. I will do my best. I think there are a number of implications. One of them is that in our review of the situation in Iowa apparently the regulations covering Medicare and particularly Medicaid, have been interpreted and the interpretation here, while perhaps no one can argue with whether or not the interpretation is proper—and it may well be proper—lends itself to changing the provision of benefits in such a way that elderly people are not receiving the benefits which we believe were envisaged by the Congress when the act was passed.

NEED FOR CHANGE IN DETERMINATION OF BENEFITS

We think one of the ways of taking care of this is to call attention to the need for a change in the way the benefits are determined. One of the things that we think would help would be for the benefits to be based primarily on the recommendations of the patient's attending physician.

Attention was called this morning, as it has been on many previous occasions, to the fact that an action may be recommended and may often be turned down by a review committee hundreds, or even thousands, of miles away. A committee which, in fact, knows nothing about the patient, or his doctor, or his problem. This causes a great deal of

hardship because it is turned down after the fact and then you have the problem of either paying for something which one thought wouldn't have to be paid for, or trying to get your money back in case you paid for it and find you shouldn't have. We think this would correct a lot of faults in the present situation.

Senator MILLER. Have you had occasion to review the proposed health maintenance organization concept which we held hearings on in Congress last year?

Dr. MORRIS. Only in part. I am not conversant with the details of it.

Senator MILLER. The reason I asked that question is because part of the reason for the health maintenance organization concept was to try to break away from the review activities of the intermediaries, which you have been referring to.

Dr. Morris, another question. Did your task force deal with the subject of home health services?

Dr. MORRIS. Yes, sir. Recommendation No. 6, which was given third highest priority by the hearing group this morning, concerns that topic. It may appear in a form which people are not used to seeing, but it is a favorite topic of mine. We ought to be talking about comprehensive home care services, and by "comprehensive" here I mean everything that could be provided to a person, for no other reason than the fact he needs them in his home, because in this way more and more people could be maintained in their own homes where they are happier, usually better adjusted, and where they, to a large extent, stay off the expensive roles of institutional care.

I think this suggestion in recommendation No. 6 of a coordinating body to form and finance, promote, develop, and establish such comprehensive home health care programs would be a marvelous way for the State of Iowa to go at this and we wouldn't even mind if other States copied it.

Senator MILLER. Do you have any recommendations or ideas about how much the development of the home health service program could relieve our hospital and retirement home facilities?

Dr. MORRIS. There are estimates of this and estimates were included in the President's task force report. Every study that has ever been done serves to suggest the tremendous savings in dollars, to say nothing of the happiness and well-being of the individual if this were open to a greater extent than it is at present. It would be sound public policy to adopt such a measure which reduces the number of days an older person spends in a hospital. Reduction of 1 day in each hospital stay covered by Medicare in a single year (based on a $50 per day charge) would result in a savings of about $250 million for the Nation.

Senator MILLER. Thank you very much, Dr. Morris.

Our next witness is Mr. P. F. Crivaro of Des Moines, the executive director of the Low Rent Housing Agency.

STATEMENT OF P. F. CRIVARO, DES MOINES, EXECUTIVE DIRECTOR, LOW RENT HOUSING AGENCY

Mr. CRIVARO. Thank you, Senator Miller.

Before giving my recommendations from this morning's workshop, I would like to start by saying that the housing committee consisted of persons actually serving in areas of housing from both rural and

urban areas. During the course of several meetings each committee member submitted information gathered in these rural and urban areas, and, as a result a committee report and recommendation was proposed.

I think our committee was very fortunate in having representation thereon from both the rural and urban areas, so we feel our committee report reflects the needs of both rural and urban people.

In this morning's workshop meeting it became evident that although the committee members did their homework well, the participation of those in attendance at the workshop enlightened further and, as a result, the committee's priorities were changed to better reflect the needs of the elderly who were meeting this morning.

From the report of the President's Task Force on the Aging, dated April 1970, we find that a recommendation was made that the Department of Housing and Urban Development, in administering Federal housing programs, recognize the needs for the elderly for specialized housing arrangements by developing and using separate guidelines for the provision of such arrangements concerning design, funding, and operation. This is real great, because this is the way we felt about it after our discussion this morning.

Release Funds for Elderly Housing

As a result the top priority being submitted to you and your committee, Senator, is that the funds appropriated by Congress for housing for the elderly be released, and not be continued to be tied up as they are at present; but that they should be usable and obtainable to meet the needs of the people. We felt that we could talk until we are blue in the face, and unless these funds are unfrozen there isn't much we can do about the things we feel people need. So we gave this top priority, and are asking very strenuously that every effort be made to release these funds that are presently being tied up.

We also feel that a higher priority should be given to the needs of the elderly as compared to some of the priority ratings given to other phases of the budget that the Government has prepared.

Our second recommendation, then—being further in line with the President's report that I just quoted from—certain arrangements should be made concerning helping not only people who are eligible for low-rent housing as far as renters are concerned, but also a number of people living in the rural areas who are homeowners—and yet they are not being accommodated the way we feel they should be. These elderly people who choose to live in their own homes—but because of their fixed income are not able to enjoy the privilege of living in their own home—in many instances are being forced to give up their properties because they can't afford to keep them up. They move into the inner cities where public housing is available. We feel, then, that priority, too, should be given to Federal assistance to homeowners, so they can maintain and stay in their own homes. Possibly some kind of tax relief to permit them to continue enjoying their last years in their own homes, in their own neighborhoods.

Our third recommendation was given to transportation. We felt that the elderly people—whether they be in rural areas or in the inner cities—have a real need for group activity because the elderly people are quite often lonely. They have no way of getting around

to the areas where there is group activities. One reason is that public transportation is very lousy, as it is in many cities that do have public transportation, and in rural areas where they have no public transportation this is a problem. So we are suggesting, then, that some type of minibus transportation be provided to take care of the elderly people—by bringing them to the various sites for related group activity.

We feel, too, that transportation should be made available to senior citizens, whether they are in housing projects or not.

The fourth recommendation that we came up with was based on many communities in the State of Iowa that have a need for housing or taking care of the elderly people. The local community is not making any effort to do so and this, of course, is a real sad situation. We are hoping, then, that some effort could be made—both at the national level and the State level—that existing funding and development departments, be reorganized, if need be, so that more time can be devoted in assisting these communities—that are doing nothing because of financial reasons, or lack of know-how—to promote housing needs for the senior citizens in that particular community.

Thank you, Senator.

Senator MILLER. Thank you very much, Mr. Crivaro.

I see that one of the recommendations that your task force has is one that I have been working on for quite a while—we haven't gotten the job done yet but we are going to continue to work on it—and that is this matter of a central office on aging to oversee the planning and execution of our policies. Right here in Des Moines we have a program under the auspices of the Commission on Aging, we have another one under OEO, and another one under Model Cities. I don't want to take away from any of them, but I think it is unfortunate we don't have a central coordinating point. They do cooperate back and forth, but there are some differences and some things that would happen which would not happen if you had a central coordinating point. I suppose you had that in mind?

Mr. CRIVARO. That was something that was discussed very much and we certainly encourage it.

Senator MILLER. Keep working on it.

Thank you very much.

The next witness is Mr. Edward K. Kelley of Des Moines, supervisor of special services, Iowa Employment Security Commission.

STATEMENT OF EDWARD K. KELLEY, DES MOINES, SUPERVISOR OF SPECIAL SERVICES, IOWA EMPLOYMENT SECURITY COMMISSION

Mr. KELLEY. Thank you, Senator Miller.

I would like to point out as we discuss employment we are using a very broad definition of the term, because as far as older workers are concerned, we are dealing with individual needs, different needs for people. For some it may be full-time employment, for some it may be part-time employment, and for others it may be merely volunteer service.

It was our conclusion the basic need of aging citizens is meaningful productive activity, the need to achieve, the desire to continue to con-

tribute to and participate in community life. We noticed in all the area reports that the expression of most older people was one of rejection, one of loneliness, but particularly rejection. The desire to achieve is one that is inherent in all of us, and I think this basic need should be fulfilled. To some this means continued employment. However, there are very few employment opportunities for older people. Age discrimination laws must be extended to cover greater numbers of elderly Americans not now protected by existing legislation.

Restrictions on earnings under the Social Security laws are prohibitive and unfair. We must give consideration to the fact that honest evaluation of older workers can only be made on the basis of functional age, not chronological age, and arbitrary retirement requirements should be eliminated.

It is the opinion of this group as we assist the older person to added knowledge and increased skills through training opportunities, retraining opportunities, increased educational opportunities, as we increase their participation in activity in community affairs, so we contribute to the total economy and the welfare of the Nation.

Thank you.

Senator MILLER. Mr. Kelley, you summarized a very big subject pretty quickly. Do you agree we are not tapping a great human resource that can benefit our country and our society?

ABILITY NOT BEING UTILIZED

Mr. KELLEY. We certainly feel, Senator, that there is so much ability existing among people in the so-called older worker group; and, that this ability is not being utilized by business and industry. Some of the things that I pointed out in my report are the barriers that exist today, myths that exist regarding older workers. I think anyone who has worked in this area is aware of them, and I think we pointed many of them out in our report that we submitted. We are just not utilizing the ability and the talent that exists among older workers.

Senator MILLER. Of course when you have a mandatory retirement age, somebody at age 60 or 65 is going to leave his job that he apparently has been doing pretty well. The only reason he is going to leave it is because he has hit that mark, and that means that when he leaves that his talents are going to be lost unless he can move into something else such as a volunteer program or a part-time program, at least.

Mr. KELLEY. It has been the experience, Senator, of those of us who are concerned with employment of elderly people that the employed older worker is a decided asset to his employer. The unemployed older worker meets with a great deal of employer resistance. This is one of the reasons why we recommend extension of age discrimination laws or expansion of age discrimination laws. As the law presently exists it covers only certain groups, and you are aware, of course, employers who employ 25 or more people, employers who are engaging in interstate commerce, and we believe these laws should be expanded. There should be State legislation to cover employers who hire four or more people, and it is true of the unemployment insurance laws.

Senator MILLER. Do you have any comments particularly on the Iowa volunteer programs?

Mr. KELLEY. I think the Iowa volunteer programs are probably—I don't know how to express this. I think Iowa is far ahead of other

States so far as volunteer programs are concerned—the ones I have observed. I am particularly knowledgeable with the Southwest Iowa Council on Aging and the activities they are engaged in for older workers. I think they have set up the first volunteer employment office for older workers. And I am very familiar with Foster Grandparents at the Glenwood School. As we observe activity around the State, I think this is increasing and I think it is encouraging, there will be more opportunities for older people in Iowa. I think Iowa is going to be looked to by the rest of the Nation as perhaps an example of people who are concerned for older workers.

Senator MILLER. What do we need to do to increase the number of older Americans in Iowa in the volunteer programs?

Mr. KELLEY. I think probably this matter of communication which exists in any program, I don't care what it is; people are not aware of the opportunities that are available, people are not aware of the necessity for participation. We find there are people who are not knowledgeable of the fact these programs are in existence today.

NO FUNDS FOR OUT-OF-POCKET EXPENSES

Senator MILLER. I can understand if they don't know about them how they wouldn't volunteer for them. But would it help to obtain more volunteer participation if there was more expense money available for traveling to and from the location, or if transportation facilities were provided better than they are?

Mr. KELLEY. This, Senator, is one of the obstacles we find. There are no funds available to reimburse people for out-of-pocket expenses. There are many people who would like to go on a voluntary basis; but they are not financially able to drive their car or pay their bus fare to the loop and to take care of their out-of-pocket expenses and they are not often able to get reimbursement for these expenses. I think this is one of the barriers to volunteer assistants.

Senator MILLER. Thank you very much, Mr. Kelley.

I apologize to the very able staff that is up here with me, which I should introduce.

On my right is Mr. John Guy Miller—he is not a relative—and Mr. Ken Dameron, on my left, who are professional members of the committee.

I am reminded by my able staff that the RSVP program does get into this matter of furnishing out-of-pocket expenses and there is an increase proposed for that program. So I think we are moving in the right direction, but I still have the feeling, and I am pleased that Mr. Kelley and his task force share it, that there is a lot of room for a great increase in activities of our older people, not only in the volunteer programs but in other meaningful activities.

Mr. Kelley, you agree, I trust, the degree to which these people can obtain meaningful activities, be they volunteer or pay, will make retirement years much more meaningful than otherwise.

Mr. KELLEY. I do.

Senator MILLER. Our next witness is Dr. Ronald C. Powers of Ames, who is the chairman, department of family environment, college of home economics, Iowa State University.

Dr. Powers.

STATEMENT OF DR. RONALD C. POWERS, AMES, CHAIRMAN, DEPARTMENT OF FAMILY ENVIRONMENT, COLLEGE OF HOME ECONOMICS, IOWA STATE UNIVERSITY

Dr. POWERS. Thank you very much, Senator.

The background for the recommendations of the educational work group who met this morning is part of the original task force report and will be part of the official record and, therefore, will not be repeated.

As a result of this morning's discussion, the educational work group adopted five recommendations, three of which have specific reference to Iowa and two which would seem to have major implications for national and State policy. The recommendations which follow represent a majority view of the group this morning and they are revisions of the preconference report.

The educational work group recommends:

1. That the main planning and coordinating body in the area of aging in Iowa should be the Iowa Commission on the Aging. This is predicated on the observation that there are many efforts, good efforts, now, but they do need some additional sense of direction and purpose.

2. That education about, for, and by the elderly be made an essential part of a comprehensive program of continuing education beginning at the earliest school-age level. This recommendation obviously has direct implication for such agencies as the U.S. Office of Education.

3. That grant proposals for educational materials and programs for the elderly be developed and extended under the Older Americans Act or other appropriate legislation. It is further recommended that the Iowa Commission on the Aging seek such funds.

4. That the Iowa Commission on the Aging encourage and initiate action research which focuses on the evaluation of educational programs for the elderly, again premised on the strong belief that we have to know the effectiveness of what we do.

5. Recommends that the Iowa Commission on the Aging encourage and initiate the development of preretirement programs by business, industry, and Government employers. And it is further recommended that additional preretirement programs be developed for those people not reached through such efforts.

This is the summary of our recommendations.

Senator MILLER. Thank you, Dr. Powers.

Dr. Powers, you suggest that the Commission on Aging be the focal point for, I assume, developing policy in this area.

Dr. POWERS. That is correct.

Senator MILLER. What about the implementation of this? Should this be handled through the local public schools; should it be handled by the extension activities of the universities?

Dr. POWERS. I believe it would be accurate to say that the feeling of the task force was that it should be handled by those you mentioned and all others which currently are or have the potential for deriving educational programs. We know, as an example, a great deal is being done by nonschool, noneducational agencies, per se, for example, the church, and for this reason we wanted to identify the Commission as

the focal point but to have most of the implementation and effort put forth by existing agencies and organizations. We wanted to begin there before we start creating new machinery for implementation.

Use Talents of Elderly

Senator Miller. I was interested in the statement on education about, for, and by the elderly, because you may know for some time I have advocated we ought to make use of some of the talents we have in the older population, many of whom have professional skills or special skills which they can impart in teaching a course not only to maybe younger students but to older people, too.

Dr. Powers. We couldn't agree more. Dr. Jacobs on our committee has believed this for a long time. And in the course of our deliberations, we called upon a man by the name of Mr. Leif Schreiner from Waterloo, who is involved in the Hawkeye Institute of Technology programs for the elderly, and I must say he personified for us an individual who is retired and is educating other people, including those people who are planning on retiring. He feels very strongly about this threefold designation of the problem.

Senator Miller. Do you know offhand whether there are any retired people who are brought in to teach a course or participate in any of the activities of the College of Home Economics at Ames?

Dr. Powers. I ought to, but I am not sure I can identify the numbers involved. We do make use of the people who have been on our staff. We do have people who have retired and are still contributing. Sometimes they are paid on a part-time basis. I am sure there are others of whom I may not be aware.

Senator Miller. You have the feeling that we are not tapping a great amount of talent there, don't you?

Dr. Powers. I think there is a great deal of talent there.

Senator Miller. Thank you, Dr. Powers.

Our next witness is Mr. Alvin Bull of Des Moines, who is the editor of Wallace's Farmer.

Your task force was on retirement?

Mr. Bull. Yes, sir.

Senator Miller. Please proceed.

STATEMENT OF ALVIN F. BULL, DES MOINES, EDITOR, WALLACE'S FARMER

Mr. Bull. Thank you, Senator Miller.

I had to ask what was meant by "retirement" to make sure what to include in the report. The first thing I found was that, if all the other task forces solved problems with which they were charged, few problems would remain. We proceeded on the assumption they wouldn't get all the job done.

Health and Income Top Priority

We did say, however, in our task force and in the group that met this morning, that top priority in policy and program consideration should be health and income. If people are blessed with good health

and adequate income, they have much wider range of options in their retirement activities. So we gladly permit these two areas to take top priority.

In terms of recommendations, the group felt that preretirement planning was important. Both State and Federal Government should play a part in this. Business and schools should, also. In the end, the program probably has to be voluntary, so in a sense, we would echo the program of the Education Committee.

We went one step further and talked about long-range retirement planning, and perhaps a better term would be "lifetime planning." This is logically a part of formal education as we expose even grade school students to the changing roles they will play throughout life. They can see fairly clearly the role of child, adolescent, parent, adult, and perhaps grandparent, but the deliniation of role gets quite fuzzy in the retirement area. I think we can help on this. After all, this aging process starts early and depends on your point of view. If you are a 2-year-old, 25 can look pretty old. So the view of aging must take a long-term aspect.

Along with this, we would like to see in terms of both education and long-term planning effort, some emphasis on how we use leisure, how can we use leisure most productively, and I don't mean in terms of work production. So we put our enthusiastic stamp of approval on pre-retirement programs.

In terms of retirement activities, this was divided into a couple of areas, and again part of this has been touched upon.

Need for Cooperation

The first major item was a tremendous need for coordination of the many agencies and programs already existing to deal with the needs of the aged. One of the existing agencies, and the State the Commission on Aging would be our choice, could be assigned this task. We see no need to create a new agency.

We also saw this coordinating agency serving as a clearinghouse for information. This gets to something I think you were touching on, Senator Miller. There is a tremendous number of excellent volunteer programs in our local communities. Other communities should know about these programs and are greatly interested in knowing about them. We find that local people are tremendously creative in this sort of thing, especially when a little bit of encouragement and leadership is provided.

We essentially have said the local community carries the responsibility for creative thinking on the ways to use volunteer people but State and Federal Government should provide significant help in gathering these ideas together and disseminating them to other local communities.

In terms of activities we also included work and touched on this very briefly, feeling those who are able to work, who need the income and want to work, should be actively encouraged.

One other item came up from our meeting today, and received almost unanimous support of the people present. This was a request that the Federal grants and aids to help provide services for the aging be continued.

Along with this I have one other item we need to add, that retirement is a highly individual matter and that individuality needs to be preserved.

Senator MILLER. Thank you very much, Mr. Bull. I think you have articulated the subject in the task force jurisdiction very, very well.

I know when you look at the other task forces you might come to the quick conclusion that there wouldn't be anything left for your task force to do, but we thought well enough of the subject in the committee to do this. I think it was 4 or 5 years ago we had a lot of subcommittees on housing for the elderly, retirement income, Federal, State, and community services, consumer services to the elderly, health and long-term care, and we finally added another, retirement and the individual.

You put your finger on a key point here, leisure time. What are you going to do with it? Are people just going to sit there and think they are not wanted, that they are not needed, or are they going to have something meaningful to do? I agree, if you look at the task force subjects here, employment and other things, that might take into account some of these things but it doesn't cover leisure time. It wouldn't cover such activities as writing letters to the editor of Wallace's Farmer.

Mr. BULL. Or to Senators.

Senator MILLER. Really, I think many of us feel that even if we cover these various subjects, health care, income, housing, diet, there has to be something else left over to make retirement years meaningful. I think we have an awful lot to do and I think you very well pointed out it is a very highly individual matter.

Mr. BULL. The encouraging thing as you get into this is the tremendous creativity of communities in getting various things done along this line. This is why we pointed out the need for a listing of successful local efforts and then making this available to other communities. The more we get knowledge of good ideas spread around, the more likely these are likely to catch on in other communities around the State and Nation.

Senator MILLER. I certainly wouldn't think you would have much trouble in getting the support of all press media to get this information spread around the State.

Our next witness is Mrs. Louise Dennler, Des Moines, dietary consultant, health facilities service, Iowa State Department of Health.

How do you do.

STATEMENT OF MRS. LOUISE DENNLER, DES MOINES, DIETARY CONSULTANT, HEALTH FACILITIES SERVICE, IOWA STATE DEPARTMENT OF HEALTH

Mrs. DENNLER. Thank you, Senator.

The background for the meeting this morning was the report of the Task Force on Nutrition of the Elderly, which included material concerning nutrition from the community meetings that you spoke of, which were held earlier throughout the State.

Of the 12 recommendations made by the nutrition section, five were considered to be priority issues, and these are being presented in the order of importance by vote of the participants in our particular section:

1. We recommend that the money income of the aged poor be increased so that they may have greater opportunity to purchase more and a variety of nutritious food. Until such a time as there be money allowance for food purchases to the aged poor and in view of the money problems, inconveniences, and of the inadequate distribution of its services to the aged poor, we recommend that the State department of social services study the food stamp program with a view to enhancing its effectiveness and convenience.

2. Provide meals by a community agency rather than determining that older people should move to an institution for the aged when older people who live in their own homes or apartments are unable to provide adequate nutritious meals for themselves. In order to accomplish this, it may be important to place emphasis on a statewide effort to provide home-delivered and community meals so that every older person in Iowa who needs this service may receive it.

3. It is recommended that—this is a recommendation that I have heard from several of the task forces—a coordinating committee made up of representatives from agencies dealing with nutrition for the aging and representatives of the consumer groups (the elderly) be appointed by the Iowa Commission on the Aging to coordinate the work on nutrition for this group.

4. Encourage and support programs of nutrition education toward: The maintenance of good nutrition throughout adulthood and in the later years of life; the development of guidelines for good dietary practices for older people; the education of those who serve the older persons in professional and related capacities in the development of special techniques and methods directed toward teaching the aged.

5. The Iowa Task Force on Nutrition accepts the recommendation of the National Task Force on Aging, recommendation 23, Nutrition Programs for the Elderly. We recommend that the President direct the Administration on Aging and the Department of Agriculture to develop a program of technical assistance and, when necessary, financial assistance to local groups so that such groups can provide daily meals to ambulatory older persons in group settings and to shut-ins at homes.

This last is somewhat a repetition of some of our specific recommendations.

Senator MILLER. Thank you, Mrs. Dennler.

That recommendation No. 2 providing meals by community agencies is already being done in some parts. "Meals on Wheels." Have you had a chance to observe the results of that program here in Iowa?

Mrs. DENNLER. Yes; we have on record 44 programs for Meals on Wheels or home-delivered meals that are doing a very good job. There are many parts of the State in which this service is not available, though.

Senator MILLER. Of those 44, how are those being handled? Who is heading them up?

IDEAS FROM WORKING PROGRAMS

Mrs. DENNLER. Each one is different, and that is one of the reasons for one of our recommendations here to coordinate these programs. We didn't mean by coordinating that they should all be the same, but

the ones that are working should be studied and then these ideas or the guidelines found from these that are working be given to other groups that wish to implement such programs. I think many of them are in part being run by volunteers and as long as the volunteers keep on having the strength and the money, maybe they will continue. There was some discussion in our group concerning the need of extra help for the delivery and/or for the purchase of meals. In situations in which volunteer delivery is not successful, financial assistance needs to be given to hire persons to deliver meals.

Senator MILLER. What I am wondering about, when you talk about a statewide coordinating effort or planning effort on this, is there any organizational setup now, such as the extension service, which could take something like this on?

Mrs. DENNLER. We really don't know. We discussed that. Each one of them is handled in a different way and successfully. Our feeling was that this committee or this agency or probably a volunteer group would work in an advisory capacity as needed.

Senator MILLER. Are any of these being handled by church organizations?

Mrs. DENNLER. Some are by church. And as far as the preparation of the meals, many are done in hospitals, the meals are prepared in hospitals and sold at a low cost and delivered by volunteer groups, and these volunteer groups may be church groups taking turns or other community groups.

Senator MILLER. But we need a lot more of them?

Mrs. DENNLER. Yes, we do. There are some areas in Iowa that have no program at all.

Senator MILLER. All right. Thank you very much.

Our next witness on the Task Force on Transportation, Mr. Herman Batts, Des Moines, director, Traffic and Transportation for Des Moines.

STATEMENT OF HERMAN A. BATTS, DES MOINES, DIRECTOR, TRAFFIC AND TRANSPORTATION, CITY OF DES MOINES

Mr. BATTS. Thank you, Senator Miller.

The report of the Task Force on Transportation prepared prior to today's hearing served as more or less background information for the hearing conducted this morning. The recommendations contained in that report I will not attempt to repeat. They have been submitted as part of the record.

Basically from a policy standpoint, both at the hearing and the Task Force committee, it is believed that the Federal Government should adopt national policies designed to promote and encourage the development of special transportation programs for the aged but that the operation of the system should be left to local transit companies and local social agencies. We do not feel that the Federal Government should be put in a position of developing special transit systems specifically for one particular element of the population.

The committee was quite concerned about the current concentration of efforts in the transportation field in our major cities which have existing transit system, considering that in Iowa over half of our population is located in rural areas and small cities where they have no mass transit system.

This led to a number of recommendations. One specifically that could be quite far reaching in its impact is a recommendation that the Federal Government should promote the development of periodic individualized transportation services in cooperation with social and private agencies. We feel this should be done through transit firms in the major cities but has to be done through social agencies on a rather widespread area basis outside of the major urbanized areas.

The problems of transportation are quite severe for the elderly residing in the small cities and in rural areas, particularly because of the concentration of low-income elderly in these areas. A considerable amount of the transportation now being provided in these areas is done on a volunteer basis.

Provide Insurance Protection

The hearing came up with a recommendation this morning which I feel has considerable merit for consideration by the Federal Government. The task force committee recommends to the Federal Government that they investigate the potential of establishing a program of providing insurance protection for the driver who voluntarily transports elderly people. In the contacts which members of the committee made with retirement homes throughout the State we find there has been a drop-off in the people volunteering to transport elderly residents because of the liability of the driver in case an accident should occur. It was the committee's feeling an investigation should be made to determine whether a special liability insurance policy could be developed for the elderly individual himself so it would protect him, and so that a driver who is voluntarily transporting him would be given liability protection in case of an accident.

I think these are the major items which were considered in the hearing. Thank you for this opportunity to present it.

Senator Miller. Thank you, Mr. Batts.

That last suggestion of your task force is a novel one, at least to me. I haven't heard of this one before, and it makes a lot of sense.

I am not trying to get you and Mr. Crivaro at sword's point here, I don't think you are, but I notice in the housing task force the recommendation is for a mini-bus type transportation service to be considered together with an elderly housing project. I don't think there is anything in your recommendation that is opposed to that.

Mr. Batts. No, sir. We think this is encompassed in some of the recommendations we have presented. We feel that the type of development of specialized programs for the elderly for housing can be worked within existing transit systems.

Senator Miller. I wasn't referring to that point. I was referring to where you would require living facilities for senior citizens to be developed with ready access to reliable transit service. If you can't do that, however, and you go over to another area, then you would accept Mr. Crivaro's idea of a mini-bus, is that it?

Mr. Batts. Yes, sir.

Senator Miller. I take it you would want to exhaust the area possibilities for locating the housing near available transit systems first before you went that direction?

Mr. Batts. That was the feeling of the Task Force committee.

Senator MILLER. I think, Mr. Crivaro, you didn't put that limitation, you didn't confine it to looking first to see whether they could locate the housing site near available transit, you wouldn't put it that way, go to where you want to go but make sure you have a mini-bus service, is that the difference?

Mr. CRIVARO. We have known each other a long time. We don't agree on everything, but we don't disagree that transportation is important in anyway we can get it. If we can do it one way, that is fine, if it takes another way, we will take that, too.

Senator MILLER. Fine.

Mr. BATTS. The program should be operated locally. That is covered in the report.

Senator MILLER. You understand the committee does not always have witnesses who agree with each other. I just wanted to make sure.

Senator MILLER. Our last witness, but by no means the least, is Rev. Russell Wilson of Des Moines, who is the program consultant, United Methodist Churches of Iowa, on the subject of spiritual well-being.

Pleased to have you here.

STATEMENT OF REV. RUSSELL L. WILSON, DES MOINES, PROGRAM CONSULTANT, UNITED METHODIST CHURCHES OF IOWA

Reverend WILSON. Thank you, Senator.

We would like to say at the outset, our understanding is the former White House Conference 10 years ago did not include a section on the spiritual well-being, and we think it is a very healthy step and a very healthy indication that we are recognizing that some of the problems that the elderly and the retired and, as you said a while ago when you used the phrase "something that brings meaning to retirement", I think we are recognizing that many of these aspects of retirement in aging are basically spiritual. Since it is a new task for us, a new subject for us, in a sense, perhaps it would be well if I just read some of the factors that the task force committee considered to be a part of a healthy spiritual well-being on the part of the elderly.

They would include a sense of personal worth, a feeling that living is a purposeful experience, a certainty that life is worth the effort, and an awareness of a power in the universe greater than one's own which enables one to face life with ultimate optimism, an assurance of some kind of immortality, a realization that one is a part of a community, and a sense of human dignity. All those, in a way, cut across many of the other subjects that have been dealt with.

RECOMMENDATIONS FOR SPIRITUAL WELL-BEING

The first, and I suppose very basic recommendation of our committee, and I would just like to describe it, is to talk about one's spiritual health of well-being without, in the same breath, talking about one's income, one's housing, one's health care, one's legal protection, which is really a fallacy, that spiritual well-being is based on the person's total well-being. The committee used such terms as the whole person, that you can't segment his social and spiritual well-being, but they are all welded together. This group would support the recommendations on adequate housing, adequate health care, taxation systems that are

fair to the elderly, legal protection, all of those kinds of things, because those definitely contribute to spiritual well-being.

A second concern of the committee is regarding the education of both clergymen and physicians. There is some concern among the people in the task force that physicians no longer—well, let me back up and say they either are too busy to do the job or they no longer understand the need of dealing with the needs of the very ill older person, and those who have perhaps terminal illness. So the recommendation is that the schools of medicine, colleges of medicine, and the theological seminaries include broader teaching and understanding of the needs of the elderly, and especially those who are meeting physical crises.

No. 3 deals with those elderly persons who are isolated or lost to the church and to social agencies in the communities. It is recommended that the State and Federal Government provide persons who are available to visit the elderly, this means house to house visitations, to help limit their problems, to act as a friend and an advocate, and to insure that they receive the care they are entitled to. I think No. 3 recognizes, Senator, that only about 50 percent of the elderly in this country are actually affiliated with the church, so when we are talking about spiritual well-being we need to be thinking beyond the activities of the realm of responsibility of churches, which I think is important.

No. 4 speaks to the coordinating of existing agencies, and there are some of those which have been financed through our State Commission on Aging with Federal funds. Some of those are being cut back and being reduced pretty drastically. There is concern in this Task Force that these programs be continued, because they have helped coordinate activities and involved churches in many ways, and you have often helped churches realize the potential with programing for the elderly that they didn't realize before.

No. 5, it is recommended that all religious groups and organizations be urged to reevaluate their programs, their ministries and services for the aging. There is a feeling in the group that while some churches are trying hard to serve the elderly, many are failing to serve the spiritual needs of the elderly and the churches and synagogues should give serious consideration to this concern.

No. 6, a little delicate, raised a little fire in the task force, recommending the cooperation of the Government and the church. We tried to state this to be fair to everybody in the group, and yet say what the group wanted to say. Although the group is divided as to whether the Government and churches should cooperate in fulfilling the spiritual needs of the elderly, there was agreement that approximately 50 percent of the aged have no church contact and the area of Government-church cooperation should be studied in-depth.

Thank you.

Senator MILLER. Thank you very much, Reverend Wilson.

On that latter point, this is always a touchy subject. We cross it every once in awhile in the Congress, and they certainly do over here in the legislature. It seems to me if the churches themselves take enough initiative, you are not going to have to worry about that. The churches, for example, in the service of Meals on Wheels get into a voluntary program, and you are not going to have to worry about some Government agency getting out there and trying to get them to move along. I am just wondering if perhaps the answer to a touchy

subject isn't the degree in which the churches themselves initiate this voluntary action.

Reverend WILSON. I think that is true, Senator. I have to honestly say, though, I don't think the churches are going to pick up that responsibility. This is personal now, I am not speaking for the committee at all. I feel that there is an area where the government can help churches and local organizations understand what they can do for the elderly. There are a lot of things that can be done and voluntary and church organizations can do them, but I think it takes the expertise of those people who understand what is possible in terms of diets and activities and social involvement. We have seen some tremendous things done in our institutions in the State with the aged, but I have a feeling this hasn't filtered down yet to the folks in the local church, so that they see the potential. I think there is an area there for the government, for both State and Federal, to help in training those people at the local level to pick up and do more.

Senator MILLER. Let me say this to you. You made the observation, and detected a note of disappointment, that the first White House Conference on Aging did not include the subject of spiritual well-being. I want the record to show, Reverend, I was not at that time a Member of the Senate. Now that I am, I want you to recognize we have included it.

Really, this has been, I think, on the basis of my experience on the committee, an outstanding group of witnesses and very high quality testimony. I understand you have reflected the views of some hard-working task forces, many of the people in the audience participated, have given a lot of time and thought in what went into those task force reports, which I said will be placed in the record of the committee, but I do want to commend this group of witnesses for what I regard as the kind of testimony that is always desired but too often not received by the committee of Congress.

As I stated at the conclusion of the testimony, during the time available, we would welcome comments from members of the audience, or if you have a question that you would like to ask one of the task force chairmen, that would be welcome, too. I am sure that none of us, including the able witnesses here, claim to have a premium on knowledge of the subject, and I would like to hear some questions, because I know we have many knowledgeable people here in the crowd.

Please give us your name and take the mike.

STATEMENT OF PAUL BECHTHOLD, DES MOINES, IOWA

Mr. BECHTHOLD. My name is Paul Bechthold, Senator.

I want to commend you on trying to attach the cost of living to social security and voting against the SST, so we will have money for some of these other things.

Senator MILLER. What my old friend, Paul, is trying to do; he read in the paper where the House has now revived the SST argument and he knows it is coming over to the Senate and he has given me a little hint that he does not want me to come unhitched, but don't worry, I am not going to become unhitched, Paul.

Mr. BECHTHOLD. Great.

This may not be so favorable, Senator. I am a registered Republican, and I have voted for you. This morning, however, a Democrat came

here, Senator Kennedy, and talked about national health insurance. Now I have taught that to my college students, I have been promoting it for years. I believe the fine work you are doing and all the work these task force people are doing is wonderful, but I am concerned we don't spill barrels of printers' ink and we put into the political hopper a program by the President, one by the AMA, and one by Senator Kennedy and others, and have something come out that is so watered down that we don't get much after all. I think we shouldn't set up any structures that will interfere with the national health program. I believe it is better for the doctors, I believe it is better for our economy in the long run, people who would otherwise be in the hospitals, walking with canes, working and paying taxes, I can't go into all that, but I am just concerned on that one factor, that we look to a national health insurance program for all ages, not just us.

I have observed in the church work that you were talking about, sometimes the church people get more exicted and appreciate their prospects of heaven more by being able to point the finger of scorn to the lost who are going to hell, and I think we middle-class comfortable people, I am not rich, but I am not in poverty either, I think there is a danger we think the poor people are always with us and we really don't want to get rid of them. We want to feel superior to somebody, and so that is my concern. Let's don't set up anything that will prevent eventually a national health insurance program for all ages.

Senator MILLER. Thank you very much.

All right, sir, give us your name.

STATEMENT OF FRANK RHOMBERG, DAVENPORT TASK FORCE

Mr. RHOMBERG. I am Frank G. Rhomberg, of the Davenport task force.

Senator, the distinguished editor of Wallace's Farmer, and others of the task force, I mention the need for an income and health program for aging Iowans and of America. I say those words to indicate it is in those terms that human dignity is best served when the individual has control of his own environment and his own resources. I would suggest that the committee, and yourself, sir, this Nation, to, achieved its greatest dignity when it makes a wise disposition of its resources. I suggest to you it is not now the case when a major portion of those resources are involved in an unfortunate war in Southeast Asia. I would ask your committee, sir, to take a leadership role in effecting an immediate end to that hostility and disposition of those resources and important programing to that which we have attempted to address today.

Thank you.

STATEMENT OF MRS. MABEL ROBBIN, PRESIDENT, IOWA RETIRED TEACHERS ASSOCIATION

Mrs. ROBBIN. I am Mrs. Mabel Robbin. I am the president of the Iowa Retired Teachers Association.

May I ask Reverend Wilson, please, what are your churches doing about making it possible for the elderly to get to church. Most of the churches, I know, in Des Moines are built with many steps up to the sanctuary floor, in fact, I couldn't go to church at all if it

weren't that the church I attend has an elevator in it. I can walk in on the level and take the elevator up. Are your churches doing anything to eliminate the steps that the elderly—who have the constant friend, arthritis, with them—can get to church?

Reverend WILSON. You are putting me on the spot, dear friend, in front of all these people.

Mrs. ROBBIN. I hope to.

Senator MILLER. May I say apropos to Mrs. Robbin's point, that the Federal Government, I hope, is doing this, they should be doing this, in connection with construction of new facilities. They have been trying to minimize, if not eliminate, these steps for just the reason that you pointed out, Mrs. Robbin, in post offices and other Federal Buildings, and I understand that there are other areas of activity on the private sector that are trying to do it. It is a real problem and I am glad to tell you, at least so far as the Federal Government is concerned, that is a policy that has been put into effect in just the last few years. For years we didn't have it that way, but we are getting acquainted with these problems, and people like you can bring them to the attention of people, calling it to the attention of Reverend Wilson before all these people, and who knows, he might be out there tomorrow taking care of those steps.

Thank you very much.

All right, sir, you are next.

STATEMENT OF MICHAEL FOSS, DES MOINES, IOWA

Mr. Foss. Senator Miller, my name is Mike Foss, and I must confess, I am a bit disappointed in Mr. Batt's report on transportation, because there were two other crucial recommendations that were made in that committee this morning. One of them was that we recommended that the Federal Government subsidize mass transportation systems where they are in operation, but where they are not in operation that funds should be loosened up so that transportation systems could be developed, and at this point we were thinking, I think, in terms of minibuses in rural areas where it is quite a distance between where the person is and where the doctors are. We heard some figures this noon that kind of convinced us where the older people are the doctors aren't, and this is something crucial.

Out of this came another recommendation which I think is crucial and has wide impact, and that was once these things get started—these new transportation systems get started—they should be operated by the people that are using them, not by a social service agency or governmental agency imposing a structure upon the older people, or anybody else, for that matter, but that the older people themselves should have a definite say in the planning, the development, and the carrying out of such transportation systems, that is, the hours they run, where they would go to, and things like this. I think we have heard it before from the other commissioners, that transportation is crucial. You can have health programs that are fantastic, but unless you get your people to them, you are in trouble.

Thank you.

Senator MILLER. Thank you very much.

Mr. BATTS. May I respond, Senator?

Senator MILLER. Yes; indeed.

Mr. BATTS. As I mentioned when I first started my discussion, I would not cover all the recommendations because of the time allowed. The motions adopted by the hearing have been typed up and I have copies here to be made part of the record.

Senator MILLER. We will have it printed in the full committee hearing record* and I think we all recognize this transportation problem is a difficult one. It is tough in the cities, but even worse out in the rural areas. As has been pointed out, in the case of an older person, unless they have a neighbor or a relative to take them in to the doctor, what are they going to do? It is pretty difficult sometimes to get a doctor to come clear out into the small rural areas. This transportation matter has been getting increasing attention, and I am very pleased you have gone into it as thoroughly as you have.

What we are going to need is some money to be able to implement some of these recommendations, and just how that money is to be provided is going to be a source of concern, too. As a matter of fact, there are some of the older people who would be very happy to pay something, some reasonable price to get transportation, and maybe some pooling arrangements could be given, can be used in this connection.

I don't think there is any one answer to it. It is probably going to require considerable experimenting in some of these committees.

Do you have any further comments on the subject of transportation?

Do we have any further people from the audience who would like to comment?

Yes, ma'am, give us your name.

STATEMENT OF MRS. PEARL ZEMLICKA, UNIVERSITY OF IOWA, COLLEGE OF NURSING, DES MOINES

Mrs. ZEMLICKA. My name is Pearl Zemlicka.

In looking at this problem of an adequate income, there is one group of people that I think are very badly in need, and this has to do with Social Security benefits that one collects, eventually. I am still not collecting mine, but it is not too far away. I understand that Social Security benefits are based on the last 5 years of salary that you have earned; am I correct? Then, perhaps, my statement isn't going to be appropriate. But there are many women who work and reach their peak of earnings and then marry and leave the work force and then go back later to work part time at a very minimal salary. I know of one instance in particular where this lady now is at retirement age and she worked, regretfully, for 5 years part time and her Social Security is being based on that income rather than her full-time professional income that she earned earlier in life. If I am in error, this can only be justified by this one person that I know of.

I am not a member of Women's Lib, but it is always interesting in a group like this where task forces are all shared by men. I don't find any ladies' names on the force anywhere, and we are all sitting up here wanting to be heard, so I am speaking.

Thank you.

Senator MILLER. Thank you very much.

I think this fact that you called attention to here, and, of course, you see, I am on the Finance Committee, too, so it is very appropriate for you to bring that to my attention. We are constantly trying to im-

*See appendix 1, p. 481.

prove the Social Security system. I think we have come a long way, but there are still some imperfections in it, and I think you have called attention to another one.

I will be happy to do what I can about it in my role as a member of the Finance Committee. I can't do anything about it in my role as a member of this committee.

Do we have another question?

STATEMENT OF MRS. MARGARETE HOWE, SERVICE CORPS, MODEL CITIES ORGANIZATION OF DES MOINES

Mrs. HOWE. I am with the Service Corps of the Model Cities Organization of Des Moines, and we are doing service for elderly people in seeing that they get meals, and things of that type, but our main problem, we find, is that we don't have enough transportation.

Now, what we find are elderly people that don't want to go to nursing homes, they don't have to be in a nursing home, but yet, under the circumstances, they are not able to get out—and back and forth—to get the groceries, do their shopping, and things of that type. We have tried by doing a lot of transportation ourselves, and then the Government, if the Government could see this, I believe they would realize it would be better for these elderly people to have some transportation to the doctor, back and forth, and that way they can live in their little apartments, and some of them have nice little homes, and be prepared for their elderly days.

What has happened is that expenses has eaten up the money that they thought they could use at this time to be comfortable and, of course, as you know, when we get our taxes straightened out, we can live; and when we get food stamps fixed, they have food to eat, but if you don't have any way to go get it and aren't able to get it, that won't do any good.

Our organization would like to have some kind of a minibus that we could take back and forth, plus the fact you know what upkeep is, and we should have a licensed driver with insurance. We would like very much to put this before the Iowa Senate and carry it to Congress so that our people can have this. I work with them, and many times my car has broke down taking them back and forth. Many have helped me in this organization.

Senator MILLER. Thank you very much.

May I ask you a question before you leave. How long have you been carrying on this particular program?

Mrs. HOWE. We have been carrying it on the latter part of December through now, from 1970 into 1971, now.

Senator MILLER. And this, you say, is under the model cities program?

Mrs. HOWE. It is under the model cities program.

Senator MILLER. But you are using your own personal transportation?

Mrs. HOWE. I have been, and there are others that have, too.

Senator MILLER. Has there been any talk about trying to get a minibus for this?

Mrs. HOWE. We are in the process of trying to get a minibus, but finances so far hasn't allowed us to have this, because our director,

Mrs. Ed Morris, knows that we will have to have the upkeep of the bus, we will have to have someone that we can, you know, depend on to drive, that we can depend on for insurance and safety for our older people.

Senator MILLER. Maybe it is because of the work you are doing. We will have some experience with this kind of a program which will enable us to do a lot more in this important area of transportation.

We want to thank you very much for your work in which you are doing, and thank you very much for your statement.

Mrs. HOWE. Yes; thank you.

STATEMENT OF MAURICE A. TePASKE, MAYOR, SIOUX CENTER, IOWA

Mr. TEPASKE. Senator Miller, we appreciate your being here to hear the people of Iowa visiting with you.

Senator MILLER. Thank you, Mayor TePaske. It is very fine of you to come all the way down here from northwest Iowa to be here.

Mr. TEPASKE. My name is Maurice A. TePaske. I am mayor of Sioux Center, Iowa, and vice chairman of the Advisory Committee for Health Planning Council of the State of Iowa.

We are deeply appreciative of the long-term interest you have shown in the problem of the aged. This is something that has gone on for a number of years, and you have made a tremendous contribution for reacquainting the public interest in our concern for our elderly loved ones.

First of all, in speaking from a rural area, and both of these plights apply to our rural area, I think one of the finest investments the Government makes is the low-rent housing in the rural areas so elderly loved ones can be cared for in the golden years of their life in their native habitat. This is not a derrogation of piling our elderly into concentrations of villages and larger centers; but when you keep them in the communities where they lived their lives, they have support of the churches and the various social activities which they spent their lives, and I think it is a very fruitful way for the Government to expend funds. We are grateful of the way you have assisted in Iowa.

Second, and probably even more so, I think the finest investment the Federal Government can make is whatever encouragement it could give to a massive increase in medical manpower. The entire tendency, because of the sophistication of the great costs of modern health care, are to concentrate health services in regional centers, which means so many of the problems which you have heard discussed this afternoon, and also are very familiar with, means they are aggravated and nothing will serve better to bring health services to the elderly than a massive increase in the number of general practitioners. Steps have already been taken by our university, the University of Iowa College of Medicine, but I feel that they are so far short of what is necessary, particularly talking for Iowa, your State as a rural State, so much of it, we need a massive increase in medical manpower retained here in Iowa.

The Des Moines Register carried a feature story last Sunday. There were 120 graduates, about a hundred of them were going to intern outside of Iowa, only 20 in Iowa. This will simply perpetuate the

serious problem, and it will get much worse before it gets better, and we invite your attention to it.

Thank you for your help.

Senator MILLER. Thank you, Mayor. Believe me, you put your finger on a very, very important problem. It is a problem that has to do with expanded health insurance programs. Unless you have the doctors out there in those rural areas, what good is it going to do to entitle them to all kinds of medical benefits? They have to have the medical manpower available to them.

What do you do in your community to handle or to try to handle this transportation problem that has been discussed considerably this afternoon?

Mr. TEPASKE. This harks me back to the first item. In a rural community of 3,500 population, almost every one of our elderly people, either those living in the 40-unit low-rent housing project, or other retirement facilities, or their own homes, have loved ones and friends that have taken care of this problem. I think your question points up how many of these things can be solved by support of churches in the community, social activities, friends, and loved ones who can take care of many of these transportation problems if the needs to be fulfilled can be taken care of. But, you see, all the medical manpower will be siphoned out of the rural areas into larger regional centers. Then it becomes an almost impossible problem.

Senator MILLER. Thank you very much.

STATEMENT OF GEORGE GARWOOD, HOSPITAL ADMINISTRATOR

Mr. GARWOOD. Senator Miller, I am George Garwood, administrator of a small hospital and a long-term nursing care addition.

If you are talking about transportation, we might give some thought to school buses. They are out every day, and there are many hours during the day when they are not being used. Of course, the problem there, again, is the elderly folks getting on the bus, but it is just a thought.

We have Meals on Wheels. You people should talk about this thoroughly. There is a small hospital in Sioux Center, and there is no reason why the hospital can't be doing this. The problem is financing. You know, every time we talk about health, we talk about financing. We have a problem right now. We are only so large; we can only send out so many meals. The problem is now developing that some of these people need Meals on Wheels, but they are on old-age assistance, and they do not have the financing, so what do you do then? The hospital sends out a meal; it cost 75 cents a day. We had a gentleman in the community who left us $20,000 to do this. This is all public relations. Of course, it would also help if the Government would help.

I heard another man talk about this business of compulsory health insurance. This bothers me just a little bit. We had a program called MAA, Medical Aid for the Aged, which took care of—in Iowa—every poor man, whether he was 65 or 2. This was well done, in my estimation. The hospitals were well paid, the doctors were paid, we did a lot of charity, and nobody was griping. We didn't have the paperwork, either. Then along come the governmental programs called Medicare and Medicaid.

Medicare is fine, because in the hospitals we don't worry, Senator, about Medicare, because the man has the money to pay and there is no problem. If Medicare turns him down, and it is doing that more and more, they are cutting down the people over 65 who they will pay for. They tell us who they will pay for, and I want you old folks to understand that when the hospital says you are not covered, it is not the hospital that says it, it is the program that tells us you are not covered, so don't blame the hospitals for this, nor your doctor. There is nothing better than we would sure like to see you people covered.

No Adequate Program

On the Medicaid, and this is the problem, Senator Miller, in Iowa for the over-65 we had a good program until 1969, and then the bottom fell out, especially long-term care. Folks, most of you can understand a $2-, $3-, $4-, $500 hospital bill with some help of some kind, insurance that you have, or something of this nature, but when you talk about long-term care and you are in a nursing home for a year or more, you are talking about all the way from $3,000 to $6,000 a year, Senator. There is no adequate program under this present setup of Medicare. It covers 120 days—if it covers 120 days—and this is the problem that we face.

Now to give you an example of what is happening to the hospital. Last year my little hospital did not collect $19,000 for Medicare because Medicare said your charges were too high to the other patients—that you charged your patients too much.

Now Medicare did not participate in the bad debts we had; it did not participate in the charities that we had; and last year we gave away $50,000 in charity that medicare says was not an expense. So what happened? We are going to have to increase our room rent, because we did not collect $19,000. One of the larger hospitals here in Des Moines did not collect $300,000 last year. This is the Medicaid for the poor man. We were better off, believe me, folks, in Iowa, from the health care standpoint when the Government was taking care of the man who could not afford to take care of his bills, but when Uncle Sam says we will take care of everybody, that is when we got in trouble. When the Government says we are going to take it over and give you all the care you want, folks, along came the thumb and the restrictions, and it is just very complicated today.

I thank you for your time, Senator, for being here, and please do something to help the Medicaid program.

Senator Miller. Thank you very much.

Let me say this to you. Last year, the House passed a social security bill and the Senate Finance Committee spent weeks on this, going into Medicare and Medicaid, and trying to resolve many of the problems which people like yourselves have. I regret to say by the time we got through with it, it was so near New Year's Eve that the House refused to take it up.

I think that we will have a Social Security bill, and I am not talking about an increase in benefits. That has already been passed. I am talking about getting into the mechanics of Medicare and Medicaid and trying to remove some of these tough problems you have referred to. I think we are going to have one sometime this year, preferably in the middle of the summer or early fall, because the House Ways and Means

Committee is operating on that right now, and in due course it will come over to the Senate, and this being a long way ahead of New Year's Eve, I would guess we would get it, and I think many of your problems will be relieved when that is hashed out.

We spent weeks, months of hearings in the Senate Finance Committee in trying to get at the root of the abuses in Medicare and Medicaid, how it fits in with hospital costs, just along the lines you have been talking about, and I regret very much we didn't get the changes through last year, but I think we will this year.

Mr. GARWOOD. I would like to make one more statement.

When they talk about the old folks, the average age of the peoples in our long-term admissions is 82.4. Forty percent have no husband, wife, nor children. One-third are now on welfare, but prior to admission only one out of every 40 was on welfare. In other words, one out of every 40 persons in Iowa could pretty well make it until he got sick. That is when the problem starts, when you start getting sick.

Thank you very much.

Senator MILLER. Thank you very much.

STATEMENT OF MRS. BESSIE LAWSON, DES MOINES, FINE, INC.

Mrs. LAWSON. I am Bessie Lawson from Des Moines. I represent FINE, Inc., 401 East Sixth Street.

We serve the elderly people at our center. We are the first that opened up a center for the elderly. We furnished it all by ourselves by donations from other people that were great in helping us. We now have a feeding program and we need help in getting food for our senior citizens.

We are doing the very best that we can. We are getting institutional foods at the present time, which is not very much, and we would like to have sufficient funds to carry on our center and to do what is necessary for the elderly people.

In a statement here from your welfare department it reads:

> If you are receiving a monthly Social Security check, you will receive an increase in your Social Security check in June and it's possible in your increase that your welfare will be reduced or even cut off.

Which will be an awful hardship on the elderly people that are depending on it. They are only getting $112 a month, which is only $1,200 a year, and that is pretty hard to live on for these elderly people. We think that we are entitled to more funds for our elderly people, and we hope you will take an active part in helping us. We know we are not going to get what we are supposed to have, because our department of social services here is going to cut us right back down to the $112 a month.

Thank you.

Senator MILLER. Thank you very much.

What this lady is talking about is simply this, that in many of the States, in fact, in most of the States, including Iowa, they have a certain amount, a certain level of retirement income, and I believe she said $112. I think it used to be $100. That includes Social Security money, and the State will make up the difference if the person gets $45 Social Security, the State will make up the difference to make it, let's say, $112.

When the Congress comes along and increases the Social Security benefits, let's say, from $45 to $60, instead of that welfare recipient receiving $15 more and having $127, they will continue to receive the $112. What, in effect, happens is that the State's treasury is getting the benefit of the $15.

I first ran into that problem back in 1955 in my first session down here in the Iowa House of Representatives. I introduced legislation during the three sessions I served on the legislature, one in the House and two in the Senate, to try to get that changed to require the passing through of the increase in Social Security, and I never could get the bill out of committee.

Well, now, down in the Senate Finance Committee I find some of my colleagues who have served as State legislators have tried to do the same thing, Senator Harris of Oklahoma is one—he tried when he was a member of the State Senate in Oklahoma to get a bill passed just like I had tried, with no success—and there are a good many of us down there who have been trying to get a mandatory requirement that the States pass through that increase in Social Security, and we haven't yet been able to get the job done.

I think we did pass a bill in the last Congress with that amendment in it in the Senate but it didn't get adopted by the House. I want you to know, however, that I started fighting that battle clear back in 1955, and the battle will continue until we get that job done.

STATEMENT OF ED POUSH, DEPARTMENT OF SOCIAL SERVICES, MUSCATINE, IOWA

Mr. POUSH. Senator Miller, I am Ed Poush from Muscatine. I represent the Department of Social Services.

I would like to thank you, first of all, for speaking on behalf of the thousands of rather forgotten people who are in nursing homes across our State. I get into these institutions to see these people only four times a year, because of my caseload, but many of these people—there is no one that ever sees them at all. The spiritual well-being, you could fall into that, these people could be given a sense of purpose and a sense of dignity if people would take the time to stop in and show them that they still are, you know, there are people who still care about them. In particular, there is one woman who is 94 and has no family. You just know no one ever comes into that room, and it is heartbreaking that people let her lay there day after day. One day is the same as the other, and it must be a pitiful existence. How much brighter her outlook would be if someone would take the time to visit with her.

Senator MILLER. How right you are. I am happy you brought this up. It is a pretty tough ordeal to be lying there hour after hour, day after day, and having the feeling of not having anyone to talk to. I would guess there are programs going on here in some of our communities in the State to do this. I don't know whether Mr. Nelson is available to tell us that or not, but there are voluntary programs for older Americans for this visitation work, and it is very, very meaningful.

Mr. POUSH. I would also like to make a thought for the grandparent program. There are some churches going into the nursing homes regularly with church services for those who can't get out. I think this would be great if this was done more statewide.

Thank you.

Reverend WILSON. May I say a word. I would like to submit this copy of the task force's full report for the record.[1] I would like to say something as a private citizen, as Russell Wilson. It seems to me one of the areas of income that is due for serious consideration is the retirement programs in business, industry, and Government, in which the person has no vested interest and the person can go from one place to the other. I can see by your nodding that you know what we are talking about. It seems that is good preventive medicine in terms of elderly persons' income, and I would urge you do everything you can to correct that bad situation.

Senator MILLER. Thank you very much. Believe me, this is one of the most important areas of need for action that I know of. It is dependent upon what approach is going to be taken. It will be one of the most controversial things to come before the Congress. It is tied into not only the Labor Department's requirements for pension funds and retirement benefit requirements, but the tax laws. You put your finger on something that is one of our most important problems, and I am sure that Congress is going to be doing a lot with it.

All right, please give us your name.

STATEMENT OF DEAN WALTERS, ADMINISTRATOR, RETIREMENT RESIDENCE DEPARTMENT, IOWA CITY, IOWA

Mr. WALTERS. I am Dean Walters, administrator of retirement residence department of Iowa City, which also has an extended care center.

I would like to second some of the difficulties in terms of Medicare. I think the answer is not to go back, because I think before we had Medicare there was a lot of people that still did not get care that needed it, but to go ahead and in this case the matter of national health care program, health insurance, so everybody is covered. Under your previous plan those people who could pay in the hospital were picking up the tab when it should have been everybody shares in this. To this extent then, I think we should have, instead of cutting off $7,800 from that time on, and then progressive tax some of us who are going to get above $7,800 are going to squeal a lot, but in terms of finance, this is one of the places we should go to get the money to provide for people who do not have it.

Senator MILLER. Do I understand what you are asking is that in the case of those who cannot afford it, that the financing come out of the general fund of the Treasury, rather than out of the Social Security tax system?

Mr. WALTERS. No: I was saying the Social Security tax, instead of stopping at $7,800, should be progressive from there on for those who earn more than that.

Senator MILLER. I must tell you this. If you do this, the next thing you know you end up saying what is the difference between that and having an income tax and then you abolish the Social Security tax and put everything into the income tax, I can tell you that those who are the most stalwart Social Security adherents will fight that until the cows come home, because they are sticking with the principle that Social Security is a form of social insurance and not welfare.

[1] See appendix 1, p. 483.

Now, we are mixing in a little welfare in this thing when we go with the minimum Social Security benefit. Some of my fellow Republicans, I might say, disagree with me, but I have long said when you put in benefits which are not properly funded by the Social Security tax system, those benefits should be financed out of the general fund of the Treasury to which money is generally paid according to ability to pay, instead of taking the money on a regressive tax system, which the Social Security system is, but with the Social Security taking away from the many low-family-income earners who are having trouble enough as it is without making up that extra amount of money. Do I get through to you on that point?

Mr. WALTERS. Yes.

Senator MILLER. It is a very important point. We have talked about this a lot. I can assure you, once you break away from the concept of social insurance, then I think we are going to have an awful lot of trouble, and you are going to break away from social insurance if you get into this graduated Social Security tax.

Mr. WALTERS. Would you consider it a break, instead of a progressive tax, at least the same percentage applied to all income, rather than only the bottom $7,800?

Senator MILLER. Well, if you do that, then you might just as well take the Social Security tax, throw it out the window, and add a certain percentage to the income tax and put it all in one. I don't claim to know all the answers on this, but I want you to know this has been discussed at great length by members of the Treasury Department, the Social Security Administration, and Members of Congress ever since I have been there. It is tough, but I would hope that we would not weaken the Social Security system by overloading it with benefits that are not financed properly under Social Security taxes, such as the minimum Social Security, but instead of overloading it, require that these benefits be paid or financed out of the general fund of the Treasury. That is fair, but if you don't do it that way, and we have gotten into some problems on that, we have a way to go, and people are already complaining, believe me. We get many letters in from people complaining about the bite of Social Security taxes, not to mention income taxes. If we make it any worse, especially on the lower income family groups, I am afraid we are going to have real trouble. So I would hope that you would favor trying to fund these areas of Social Secrity benefits which cannot be traced to real actuarial financing under the Social Security taxes, have them paid out of the general fund of the Treasury. I think you might achieve your purpose if you did it that way.

Mr. WALTERS. Thank you.

Senator MILLER. Thank you very much.

STATEMENT OF CLARENCE TOMKINS, FRIENDSHIP HAVEN, FORT DODGE, IOWA

Mr. TOMKINS. I am Clarence Tomkins, of Friendship Haven, in Fort Dodge, Iowa.

You are a popular man at our place, the people love you.

Senator MILLER. Well, that is because I went up there and I gave a pen that the President of the United States used to sign the Older

Americans' Act to that great little old lady who was 100 years old the day I gave it to her.

Mr. TOMKINS. She loves you for it.

I hope there can be some breaks on the inflation for 5 successive years. The minimum wage has upped our budget $100,000 on a group of people who have a fixed income. They come and cry on my shoulder and being a clergyman, I am soft, I am sympathetic with them, and go out and work harder for some more money to supplement their care.

Any question about that?

Senator MILLER. I was wondering, are you covered by the Federal minimum wage law?

Mr. TOMKINS. Yes, we are.

Senator MILLER. You are.

Mr. TOMKINS. In fact, we are under attack right now of $175,000 penalty for using volunteer people.

Senator MILLER. Using volunteer people? There ought to be some way of avoiding some of these problems in the case of the church-operated activities.

Mr. TOMKINS. That sounds good.

Senator MILLER. There ought to be, there are a lot of things that ought to be that aren't, and I share with you some concern about the increase in the minimum wage at a time when you have inflation and when we are trying to slow it down. I think we are making some progress. The inflation rate for the first quarter of this year was 2.7 percent. That is more than it ought to be, but it is a lot better than 5 or 5½ or 6. I don't know what Congress is going to do about this minimum——

Mr. TOMKINS. We, of course, suffered under the increase from $1 up to $1.60. On the way down, we were hearing that the Department of Labor was going for $2.

Senator MILLER. That $2, I think, though, the last segment is going into effect in 1974. I noticed the Secretary of Labor testified yesterday he was very much opposed to the proposal of the AFL-CIO, which I think was to put most, if not all of it, into effect by the 1st of January of next year. He pointed out that they couldn't support that. I think it was $1.60 to $1.70 by January 1 of next year, instead of $2, and it was stated very forcefully this would have a high inflationary impact at a time when we are trying to slow the economy down.

Mr. TOMKINS. Each nickel of increase in the minimum wage means $112 a year or so, of course, every time many nickels, as you up the minimum wage, it increases the minimum wage requirement on a group of people who are ill-prepared to handle it.

Thank you.

Senator MILLER. Let me ask you this. You mentioned the volunteer services you are having trouble with now, having trouble with the government over——

Mr. TOMKINS. Yes.

Senator MILLER. What is the trouble about?

Mr. TOMKINS. It sounds silly, but we had some of our residents stuffing mail. They love to stuff mail, get together, visit, drink coffee, and stuff mail. The wage and hour man came in and said out with it, you will have to stand a penalty for 2 years in arrears of what you have been doing. I talked with the regional wage and hour man at

Denver last month. He maintained that volunteerism was out, and I said there would have to be more to make up the cuts for the payroll to keep up with the minimum wage. We didn't get into any hassle, but we were struggling with the problem.

Senator MILLER. Well, suppose one of the people out in Friendship Haven wanted to do some typing just to keep occupied, they came down and did some typing and some correspondence with you, and this was a voluntary thing and they did not want to be paid for it.

Mr. TOMKINS. We don't require them to do it. It is because they want to do it, but he says it is out.

Dr. MORRIS. You have to be paid.

Senator MILLER. This troubles me, though. If you don't get some satisfaction out of it, I would appreciate it if you would write me personally on it.

Mr. TOMKINS. Thank you, Senator.

Reverend WILSON. May I comment on this.

If it is a matter of interpretation on the Labor Department's part, it seems to me there needs to be some examination of the whole concept of volunteerism in institutions where people are confined to that institution, as in the case of the elderly. This is a conflict between the Labor Department's concept of volunteerism as taking the place of a paid worker, and a therapeutic concept that the institutions have that when the people are active and doing something, they are happy. There is an obvious conflict, and that is the reason for that.

Senator MILLER. You send me something on that and I will be more than happy to look into it.

Mr. WALTERS. I might say some of the problem in this, in some situations there are some administrators who are using a lot of patients to do work which perhaps should be done by hired labor, so there is a problem here of clarification of what does need to be done.

Senator MILLER. I am assuming we are not in disagreement over the facts. If it is a matter of fact this is not voluntary, we are not talking the same language, but where you have volunteers, there is this therapeutic thing that Reverend Wilson referred to, and then if there is a statutory interpretation problem on this on the part of the Labor Department, I want to find out about it, if there is anything I can do. I would be more than happy to see about it. I can see problems in this area, but I can't see any problem on purely a voluntary situation.

Well, ladies and gentlemen—do you have a question?

STATEMENT OF W. H. BARNAM, ASSOCIATED GROUPS OF ELDERLY, MONTEZUMA, IOWA

Mr. BARNAM. Senator, my name is W. H. Barnam from Montezuma, representing the Associated Groups of Elderly of Iowa.

We have heard, I think, a very constructive presentation today. We have heard a lot of criticism, probably some of them justly so, but I would like to throw the thing in reverse. I think that the people who attended this meeting today should be commended, giving of their time and of their energy and talent to be away from their businesses and their professions, and whatnot, to attend a meeting of this kind. This leads me to the conclusion that the people in the State of Iowa,

by and large, are in sympathy with the program that we are talking about. We have made progress, some of us think we haven't made enough progress in certain areas, but we have made progress, and it is only through the understanding of these committed people who have been here today and others like them who would have liked to have been and couldn't. I want to say thank you on their behalf and on my own behalf, that there are people who are concerned with the problems of the aged.

Thank you.

Senator MILLER. Thank you very much.

If there are no further witnesses, I think we have exhausted the patience of our fine panelists who have been sitting here very patiently, and I hope deriving some benefit from the colloquy and the discussion with the audience. I want to again commend the fine panelists, and I want to thank the able staff people for setting this meeting up out here. I want to thank especially all those who attended this meeting. We understand people coming in and out, that is done all the time in the Senate and the House, and this has been a long day for you.

I don't know if we can think of an award for those who stayed through it all, but we will try to do something, perhaps send you a copy of the hearing.

We do thank you for coming, and as I said, the record will be kept open for 30 days. We welcome any comments you wish to write to us on the forms that are in the back of the room.

Thank you.

The committee is in recess, subject to the call of the Chair.

(Whereupon, at 4:30 p.m., the committee was recessed, to reconvene at the call of the Chair.)

APPENDIXES

Appendix 1

REPORTS OF IOWA STATE WHITE HOUSE CONFERENCE ON AGING, DES MOINES, IOWA, MAY 13, 1971

ITEM 1. REPORT OF IOWA TASK FORCE ON INCOME

RECOMMENDATIONS

1. Immediately establish a minimum level of income for all aged at the "Poverty Threshold." "This cliff hanging level may be approximately $2,000 for a couple and perhaps $1,500 for an individual." Then, adjust upward to the Lower Budget level ($2,891 for a couple) when economy recovers sufficiently to bear the added expense. (Note—similar Lower Budget level standard needed for individuals.)
2. All basic floor income payments should be handled through Social Security facilities by increasing the minimum benefit (no exclusion of any aged person for lack of "coverage"). Payments to be treated as ordinary income for income tax purposes by all beneficiaries. Financing would be provided by increasing Social Security tax rates employees and employers and by taxing those employees and employers not now paying Social Security tax.
3. Government "intervention" in the areas of individual savings and private pensions is essential to improving income adequacy—and income security—for today's aged and tomorrow's aged. The basis needs are curbing inflation, full employment of tomorrow's aged today, enacting legislation for fiduciary standards and reasonable vesting in private retirement plans, enacting legislation supporting more adequate funding in private retirement plans, and enacting legislation supporting broader coverage of workers under private retirement plans.
4. Health care benefits should be extended to all the aged through a single agency, probably Medicare. Benefits should be substantially increased to cover most of the health care costs but should contain deductibles and co-insurance to maintain the continuing interest of the patient in early recovery.
5. Provide a tax moratorium on increased property taxes to the aged; unpaid taxes resulting from the moratorium to be collected when the property is sold. Propose construction and maintenance of rental housing supported by low cost federal financing and according to federal standards. Favor freedom of choice by elderly as to housing, with goal of geographic distribution throughout the community rather isolation in enclaves. Recommend study of alternate ways to cope with the inadequate supply of rental housing.
6. Urge a total approach to providing an adequate income for the poor, all of the poor, both the non-aged and aged.

ISSUE 1

The long-range goal for older people is that they should have income in accordance with the American standard of living. What should be regarded as an adequate income for older couples and older non-related individuals?

POLICY RECOMMENDATION

A national standard of living for *all* the aged should be set at the retired couples "Lower Budget" level established by recent Bureau of Labor Statistics studies.[1] Area differentials (increases)—if any—should be the responsibility of State and local governments.

This proposal envisions a two-step approach:

[1] Development of a similar standard for *individuals* is also needed. The couple "Lower Budget" in Spring 1967 was $2,671, in Spring 1969, $2,891.

a. Immediately establishing a minimum level of income for all aged at the "Poverty Threshold."[1]

b. An upward adjustment to the Lower Budget level when the economy recovers sufficiently to bear the added expense.

Payments at both steps should automatically fluctuate based on the prices of commodities and services the aged may be expected to purchase/use.

ISSUE 2

In our system in which society has accepted responsibility for assuring older people a basic floor of income at not less than the level of poverty, how should it be provided: through the contributory Social Security system? Some form of payment from general revenue? Or a mix of the two?

POLICY RECOMMENDATION

All basic Floor income payments—as described in Issue No. 1—should be handled through Social Security facilities by increasing the minimum benefit (no exclusion of any aged person for lack of "coverage"). Payments are to be treated as ordinary income for income tax purposes by all beneficiaries. Financing would be provided by increasing Social Security tax rates for employees and employers, and by taxing those employees and employers not now paying Social Security tax.

This Proposal has the following features:

1. Use of an existing agency with facilities for administration of such a system would be economical.

2. Approximately 2 million aged will start receiving Social Security for the first time—and in amounts greater than current minimum benefits under Social Security—thus a truly national program.

3. Several millions more of the poor aged would receive a substantial increase in Social Security benefits.

4. No aged would be below the national poverty threshold. The money is spent where the need is greatest.

5. Taxation of payments would result in lower net payments to beneficiaries whose other income is near or above adequate income levels.

6. Financing should be handled within the Social Security mechanism to assure that contributions will be adequate and closely tied to payments. Costs appear within the realm of practicality, perhaps in the range of 1%–2% (from each of employee and employer) of payrolls subject to FICA (Social Security) tax.

We recognize the existence of the Railroad Retirement Act, and recommend it be handled in the same way as suggested in Issue 1 and 2 (benefit under either Railroad Retirement or Social Security to exclude the individual from the other).

ISSUE 3

In view of the growing dependence on private pensions and individual saving for retirement income above the basic floor, should Government intervene to foster increased coverage and to insure receipt of benefits by workers and their survivors? Or, should such matters be left entirely to the private sector and the individual?

POLICY RECOMMENDATION

Government "intervention" in the areas of individual saving and private pensions is essential to improving income adequacy—and income security—for today's aged and tomorrow's aged. The following are the *basic* needs.

1. Curbing inflation is vital.

a. Inflation cruelly diminishes the worth of the accrued personal savings of the present aged. (77% of the aged in 1969 had modest assets other than a home—and the proportion of the aged with such assets has been increasing.)

b. Inflation makes it difficult for today's workers—tomorrow's aged—to put away personal savings in meaningful amounts—especially those workers who are

[1] This cliff hanging level may be approximately $2000 for a couple and perhaps $1500 for an individual.

unable to increase wages faster than inflation. And inflation erodes those savings as they accrue.

c. Inflation diminishes the worth of private pensions. It is not realistic to think that all sponsors of private pensions can effectively provide increasing benefits to retired employees—by whatever device. Plans of defunct employers, in dying industries, in industries with high proportions of older workers are especially unable to fight the inflation curse.

2. Full utilization of non-aged talents is essential.

a. If tomorrow's aged are more fully employed today, they arrive at old age with (1) higher Social Security (2) larger private pensions (3) greater personal savings.

b. Upgrading the work opportunity for the unemployed, the underemployed, the minority groups is vital to adequate and secure old age income.

3. Enact legislation for fiduciary standards and reasonable vesting in private retirement plans.

4. Enact legislation supporting more adequate funding in private retirement plans.

a. Modify the deduction limits on employer contributions to allow full funding of accrued benefits, and advance funding of benefits not yet accrued.

b. Allow tax deduction of employee contributions locked in for retirement purposes.

5. Enact legislation supporting broader coverage of workers under private retirement plans.

ISSUE 4

Recognizing the higher illness and disability rates among the elderly their lower average income, and the rising costs of health care: (1) should payments for health services to older people continue to be a shared responsibility of Government and the individual; (2) should coverage under the present Medicare-Medicaid system be expanded to provide full payment for all health services required by older people; or (3) should the country adopt some form of national health insurance plan which would include middle-aged and older people along with the rest of the population? An important consideration is the source of the funds used for payment for services; depending upon the policy adopted, these may include payments into an insurance fund, monies derived from income and other taxes, direct payments by recipients of services.

POLICY RECOMMENDATION

Health care benefits should be extended to all the aged, through a single agency, probably Medicare. Benefits should be substantially increased to cover most of the health care costs but should contain deductibles and co-insurance to maintain the continuing interest of the patient in early recovery.

Recent estimates of HEW indicate that Medicare is paying about 47 percent (FY 1969) of the total health care costs for the aged—not including nursing home expenses—and that per capita expenditures for the aged are approximately $590 per year (FY 1968). There is inadequate allocation of funds *even in the Bureau of Labor Statistics Lower Budget* to meet medical care expenses not paid by Medicare.

Medicare benefits should be extended to cover, on the average, 75 percent of the cost of health care, by increasing the Social Security Medicare tax rate. By using deductible and co-insurance features, benefits would cover from only a small portion of lower-medical expenses up to a very high percentage of large expenditures. Plan benefits should be subject to periodic adjustment to insure that medical expenses are adequately covered.

ISSUE 5

Does the relatively low income status of the older population together with the increased need for financial security warrant action by the Federal and/or State Government to help them to continue to live in their own homes through partial remission of property taxes or through some other means? Or, should older home owners share equally with younger people in matters of property taxes and other financial responsibilities of home ownership?

POLICY RECOMMENDATION

1. *Home owners.* We propose a tax moratorium on increased property taxes to the aged: unpaid taxes resulting from the moratorium to be collected when the property is sold.

2. *Increasing Supply of Rental Housing.* We propose the construction and maintenance of rental housing be supported by low cost federal financing and according to federal standards enforceable through an existing agency.

3. *Freedom of choice.* We favor freedom of choice by the elderly as to housing (with one goal their geographic distribution throughout the community rather than isolation in enclaves).

4. *Dealing with inadequate supply of rental housing.* In communities where the program in 2 above has not yet produced adequate supplies—so that rents would exceed a reasonable proportion of the Lower Budget (see Issue #1, we are in disagreement as to effective remedies:

a. Some favor rent control based on a reasonable return on a fair valuation of the prorperty—opponents fear deteriorating quality and constricting supply.

b. Some favor rent supplements—opponents fear major problems in determining who gets supplements.

We recommend study of alternate ways to most effectively cope with inadequate supply—the selected alternate to improve, not worsen the situation.

Issue 6—Adequate Income for the Poor—All the Poor

Policy Recommendation

The poor *aged* are the concern of this conference. Poverty is not the special province of the aged—many non-aged Americans are poor. Greater numbers of *minority group* poor are non-aged than aged.

Special pleadings to lift the incomes of the poor aged to the upper edge of poverty or beyond—if successful—create the nonsensical image of a birthday near the end of life increasing a poor person's income.

In our view, the case of the *poor as a whole,* and their special common condition of inadequate income, needs examination and solution as a whole. Otherwise, the separate special pleadings by the aged, by welfare mothers, by the unemployed, by Appalachian whites, by ghetto blacks, by migrant farm workers will inevitably result with their unequal bargaining powers in relative under emphasis and over emphasis in an income floor.

We urge a total approach to the most basic problem of providing a floor of income at or near the poverty threshhold. We recognize the seeming contradiction between this position and that in Issue 1. In Issue 1, we were responsive to the question *as put.* Here we speak out to the larger issue.

ITEM 2. REPORT OF IOWA TASK FORCE ON HEALTH

Introduction

The health needs of the elderly are often more extensive than for other age groups, requiring more professional attention, hospitalization and other institutional or home care, and should be regarded as one of the most important segments in overall health care delivery. It appears that too little is being done in research, prevention and rehabilitation as well as the actual delivery of services for this age bracket of American Society. However, any proposed changes in the delivery of health services must strengthen the quality of care and emphasize prevention and rehabilitation without necessarily increasing costs or further overloading the various health care facilities. Fiscal mechanisms such as private health insurance, Medicare and Medicaid exist to support these goals. Where they do not, adjustments must be made or new mechanisms devised.

There are a number of factors which may contribute to the increasing number and complexity of health problems of this age bracket. The immediate family of the aged person may feel no responsibility or be unable to provide care in the family home. Physicians, nurses or other health personnel have received too little training in geriatrics. Their number is inadequate to meet the demands for health services for the aged. Though many facilities have been built, the services are often poor in quality. Many aged persons must live within an inadequate income, and as a result are unable to afford ordinary creature comforts, and adequate diet and in general are forced to live under conditions which contribute to ill health. Treatment is often neglected because of the relative inaccessibility of health services. The elderly are confused and frustrated by

complicated procedures, red tape, and long delays which seem characteristic of such programs as Medicaid and Medicare. There is a shortage of rehabilitative care for the aged due to the lack of physical therapists, occupational therapists and social workers, who even when they exist, are often not previously trained for working with the aging and aged.

To this list there must be added a host of demographic factors which are not among the least important in a State such as Iowa which is in a rural-to-urban transition (which also means agricultural-to-industrial transition in its economy). Furthermore, the demographic features are directly related to the availability of facilities and personnel. Little needs to be said regarding the financial plight of the elderly, most of whom by necessity are living on fixed incomes in an inflated economy.

To illustrate the importance of the demographic features, it should be noted that on the basis of a senescity index, which reflects the relative weight of the population of an area (such as a county) which is 65 years of age or older, modified by such factors as the median age of the population of the area, the ratio of older persons to younger persons, and the number of older persons per family unit, it is possible and illuminating to identify counties which have high index values and to compare them with counties with low values. This would be like comparing a county with a relatively high old age population with one with a relatively lower old age population. When the situations in such counties are related to other important variables such as economic, social welfare and health care implications, the problems become much clearer and dramatic.

For example, in the "old-age" (i.e., high senescity) counties studied in a recent investigation, the median per capita income in 1965 was $1,450 with a range from $100 to $1,900. Contrast this with a group of "younger age" (i.e., low senescity) counties in which the per capita income was $1,900 with a range from $1,600 to $2,850. Closer examination of this situation reveals that 13 Iowa counties with populations of 10,000 or more have a greater percentage of the State's income than they have of the State's population; and the greater the population becomes in excess of 10,000 in such urban centers, the greater is the difference in percents of State income.

For the older age group as a whole, income figures are appalling. One is led frequently to wonder how many of these people manage to keep body and soul together at today's prices. Here in Iowa the median income for women 60 years of age is $1.300, with 11 percent reporting less than $500 annually. The situation with men is not quite as bad, but it is bad enough. The median income of men in this same age group was reported to be about $2,500. As age increases, median incomes sharply decrease. Finally, there is a clear tendency for the incomes of the elderly to be lower in the high senescity counties compared to the low senescity counties.

The social welfare needs of older people tend to focus on their need for health care, protective services, help in maintaining their homes, etc. In the high senescity counties the 1965 per capita expenditures in the form of "Old Age" payments was around $27.00; but only about $9.00 in the low senescity counties. It is also revealing to learn that in the former counties approximately 72 percent of the total welfare budget was spent on the aged, while only 56 percent was spent for this segment of the population in the low senescity counties.

More directly pertinent to considerations of the health care needs of the aged are those factors involving health manpower and resources. The data show that in the 20 counties with the highest senescity index values there were only 178 medical doctors (which is about 6 percent of the total number of M.D.'s in Iowa) to care for about 9 percent of the population. On the other hand, in the lower senescity countries there are about 1,779 or over 60 percent of the State's M.D.'s to care for only 46 percent of the State's population.

Again the counties with the greater number of aged people have 563 active nurses (about 6 percent of the State total); and approximately 528 general hospital beds (less than 5 percent of the State total). In contrast to this are the counties with a lower average age which have a total of 5.245 nurses (55.5 percent of the State total); and 7,172 general hospital beds (61 percent of the State total).

In evaluating the impact of the foregoing, it should be recalled that hospitalization is more frequent among older people and, because of the higher prevalence of chronic disease in this age group, their stay in the hospital is often longer and consequently, more expensive.

In terms of long-term care beds available in 1965, the median number of such beds in the high senescity counties was zero since 12 of the 19 counties had no

long-term care facilities (as defined by the Iowa State Department of Health) at all!

A final word on demographic characteristics will provide a glimpse at what may be anticipated in the future. Health Department projections show that while in 1940, 9 percent of the population (228,000) were over 65, this proportion has steadily increased and probably will continue to do so into the 1980's: 1950—10.4 percent (273,000); 1960—12 percent (328,000); est. for 1970—14.5 percent (409,000); and est. for 1980—15.7 percent (453,000). During this same period the ratio of "producers" (those in the age range of 20–65) to "retireables" (those in the age range over 65) declines to a projected 3.13 in 1980.

Your attention is also called to a bill (SF 234) which has been introduced in the Legislature to provide for a public conservator, permitting one or more counties to appoint a public conservator, who shall serve as required by the court, and shall be paid from the income of the conservatorship or from county funds. The intent is to provide protection for the needy elderly or others who may be subject to deceitful practices. Though this is not directly a concern of the Health Task Force, indirectly it has a great deal to do with the health of the aged and is greatly needed.

I. HEALTH MANPOWER

A. General Considerations

As it was noted in the Introduction, there was no question about the imbalance of health manpower in the State of Iowa in relationship to the distribution of the old age population. There is no question about the importance of health manpower in the delivery of health care services. As a matter of fact; most of the health services are related to the available number of health care providers. A recent very thoughtful and thorough analysis of Iowa's health manpower status should be required reading for anyone concerned with this question. (*Health Manpower Resources: Patterns and Trends, A Study of Health Manpower in Iowa* by Mario F. Bognanno, James R. Jeffers, and Calvin D. Siebert, Jointly sponsored by: The Standing Committee on Health Manpower Comprehensive Health Planning Council—State of Iowa—Iowa Office for Comprehensive Health Planning—the Iowa Regional Medical Program and the Health Economics Research Center, University of Iowa).

On the following pages of this Report will be found an excellent summary comparing selected health care indices in the U.S., Iowa and adjoining States. In these comparisons the authors included studies of the numbers of physicians (M.D. & D.O.), dentists, active professional nurses, pharmacists and short-term hospital beds. Among the conclusions were the following:

Iowa compares favorably with the nation and adjoining states in terms of pharmacists, professional nurses and short-term hospital beds. However, some qualifications are in order. First, while it is safe to assume that the bulk of pharmacists are fully employed, little is known as to how much of their time is spent providing health services (dispensing drugs) and how much time is spent managing a drug store.

Second, the data for professional nurses do not distinguish between those who are working only part-time from those who are working full-time. Moreover, the data do not distinguish those nurses who have an active licensure status, but who are not working, from those who are actively engaged in nursing.

Finally, the data on hospital beds imply nothing about utilization or occupancy. It is well known that several Iowa hospitals that are located in rural areas lack significant facilities. As a consequence these institutions are perhaps hospitals in name only and really function as overnight clinics for the physicians having staff privileges in them. Occupancy rates in such cases are extremely low and bed availability represents idle capacity not being utilized—therefore not needed.

There is no question about the virtual full-employment status of both physicians and dentists. Iowa ranks low relative to the nation and neighboring states in terms of the availability of physicians and dental services to respective populations.

The report also makes the following significant conclusion:

"The reader will recognize that—accepting the limitations of the data available—this study for all its comprehensiveness and depth represents only part of the overall picture of the anatomy of Iowa's health services industry and how it functions in relation to Iowa society. Recognition of this fact suggests that ultimate policy decisions should be made with an eye toward the total functioning of the whole industry of which health manpower is merely a single component, granted that it is a very important one."

Recommendation 1.—It is recommended that the Comprehensive Health Planning Council be charged to undertake additional detailed studies of the health care manpower available in Iowa to provide health care to the elderly, to include studies of health care needs of the elderly and the possible loci of care (in their own homes, in custodial, nursing, county, retirement homes and hospitals), all with an eye on determining more factually than has even been done heretofore what the health care manpower and service needs of the aged are.

B. Health manpower education and training

With a better determination of the health needs of the elderly, planning for educational programs to train the kinds of health personnel needed could be accomplished; the level or depth of such training would be known better; and, hopefully, programs could be implemented in the appropriate educational institutions of Iowa. Momentarily there are almost literally no educational programs in the state which focus on special training or education for health personnel to care especially for the aging and aged.[1]

Recommendation 2.—It is therefore recommended that the Governor impanel a Commission of Educators representing the various types of educational institutions in Iowa (the State Universities, Community Colleges, Private Colleges, and the Public Schools) with professional providers of health services to plan and work toward the implementation of educational programs to bring Iowa's health manpower force up to the level needed to assure quality health care to Iowa's aging and aged citizens.

II. HEALTH CARE FACILITIES

A. General

From the introductory comments it is clear that there are serious imbalances in the availability of health care facilities for the aged in Iowa. Some areas of the state, and especially those with a high proportion of elderly citizens, are critically short of all types of beds (acute care, extended treatment, skilled nursing home care, intermediate nursing home care, and custodial care).

In considering the problems of adequacy of health care facilities, the Task Force had in mind the involvement of Areawide Health Planning Agencies using as units of area the 16 regions of the State designated by the Governor. It was also envisaged that in developing a Master Plan, consideration would be given to the provision of personnel and facilities for a full range of geriatric services including training and employment of community health aides, transportation of patients to and from health care facilities, the inclusion of regularly available home health care programs, and the institution of such preventive techniques as mass screening and health education.

The Health Facilities Service of the Iowa State Department of Health has over the years carried on a study of hospitals and related health facilities, and of particular interest in this report, programs for the care and accommodations of older population groups (the two most recent reports being "Iowa Program for Basic Hospitals and Related Health Facilities", July 1, 1969; and "A Recent Survey and Plan: Iowa Program for the Care and Accommodation of Older Population Groups", July 1, 1970). These reports should be required reading for anyone truly interested in the problems of health care facilities for the aged. They describe currently existing facilities, evaluate them, present basic population trends and projections. In addition, a straight forward method of establishing a generalized and overall view of the composite total facility needs of a particular area is provided. The premises governing these mathematical conclusions must be recognized at the *maximum* number of beds in each category (hospital, extended treatment, skilled nursing care, intermediate nursing home care and custodial and congrete living). This method is given in terms of numbers of beds per thousand population to reflect maximum bed needs of an area.

Recommendation 3.—It is recommended that the State Health Department Health Facilities Service be charged to determine the optimum needs for all types of health care facilities for all areas of the State, and that based on such a determination of needs, a State Master Plan be developed which will assure adequate numbers of beds of all types for all areas of the state. It is further recommended that whatever legislative authority is required be enacted along with appropriations of sufficient funds to assure the development, evalua-

[1] In this context "health manpower" is used to include: dentists, dental hygenists, medical doctors, nurses, nutritionists, osteopaths, occupational therapists, pharmacists, physical therapists, recreational therapists, speech therapists and others.

tion and implementation of such a State Master Plan at the earliest possible moment.

2. Long-term Care Facilities

In a number of instances Iowa's elderly citizens are being not too subtly cheated of the quality health care they need and deserve. The Medicaid Program is designed to provide health care for that segment of the older population unable to foot the bill for itself. While in January of 1969 approximately 2,000 patients received skilled nursing home benefits from this program, by November of 1970 this had dropped to only 112! While the national average shows 30 percent of Medicaid funds were spent for skilled nursing care, in Iowa less than 2 percent of Medicaid funds were spent for this kind of health care. In this respect Iowa ranks lowest among the fifty states.

While a little over a year ago 80 nursing homes were certified for Medicare, at this writing there are only 52 still participating in the program, and more are dropping from the list weekly. In terms of beds, the loss is from 2,830 a year ago, to a present 2,351. (See Map)

Since by the very nature of these programs the aged ill are promised an important health care resource which is being denied them by virtue of a lack of facilities, they are being effectively cheated of the care they need, deserve, and by law have a right to expect.

The seriousness of this problem is even more striking when seen in conjunction with the severe limitation placed on health care services due to the relative lack of professional health personnel or its imbalanced distribution.

The Task Force urges that every effort possible be made to secure for the aged ill the same high quality of care Americans have come to expect from their doctors, nurses and other health professionals in their care of patients in hospitals. In order to effect this, it will be necessary to develop the basic concept of a Health Care Facility System designed to provide a continuum of health care. One of the problems encountered now is to see to it that once a Health Care Facility is established, it will do what the planners set out to do when the facility was planned. Perhaps authority is needed to franchise health care facilities to help correct this defect in the system.

Furthermore, if the implementation of the following recommendation requires the training of physician assistants and other allied health professions personnel, then the required legislation should be promptly enacted to make such help available. Finally, the Task Force believes that to be most effective, the efforts to attain these goals must involve the entire community: churches, hospitals, voluntary organizations, as well as the families of the patients. (N.B. See also the later sections on Medicaid and Medicare).

In view of the foregoing, therefore

Recommendation 4.—It is recommended that the necessary steps be taken immediately to assure Iowa's aged population the full benefits of both the Medicaid and the Medicare programs.

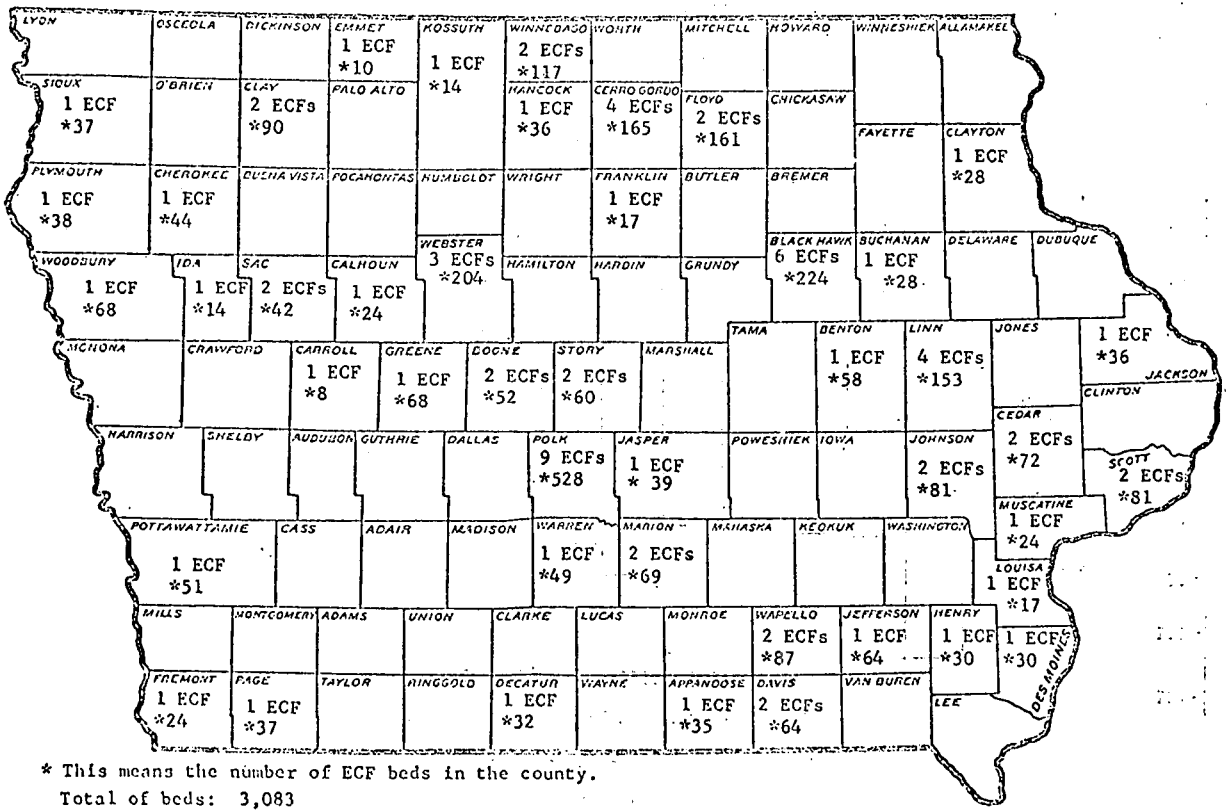
Recommendation 5.—It is further recommended that the provision of quality health care be made a part of the licensure requirements of all extended treatment, skilled and intermediate nursing care facilities, both private and governmental.

III. HOME HEALTH CARE SERVICES

Home Health Care Services, conceived broadly, should include not only health care but Homemaker Health Aide Service as well. Such programs have been devised to provide assistance and support to professional personnel in both their fields of health and social services. Properly designed and supported such a comprehensive service could provide a wide variety of services to meet the needs of the elderly. Its design is to keep the patient in his own home and to help him be as self-sufficient as possible.

As encouraging as the growth of these services to the aging has been over the last four (4) or five (5) years, (Figure 1) the services do not reach all of the elderly who could benefit therefrom, nor are the programs receiving anywhere near the financial support needed to really create viable home health care programs. The Task Force also finds the source of difficulty in the lack of clarity concerning what agencies of the government should control these programs. At the moment, support for programs comes in part from the Department of Health and the Department of Social Services. The Task Force believes an inter-department coordinating body might be a solution to this problem.

Effective April 1, 1970



* This means the number of ECF beds in the county.

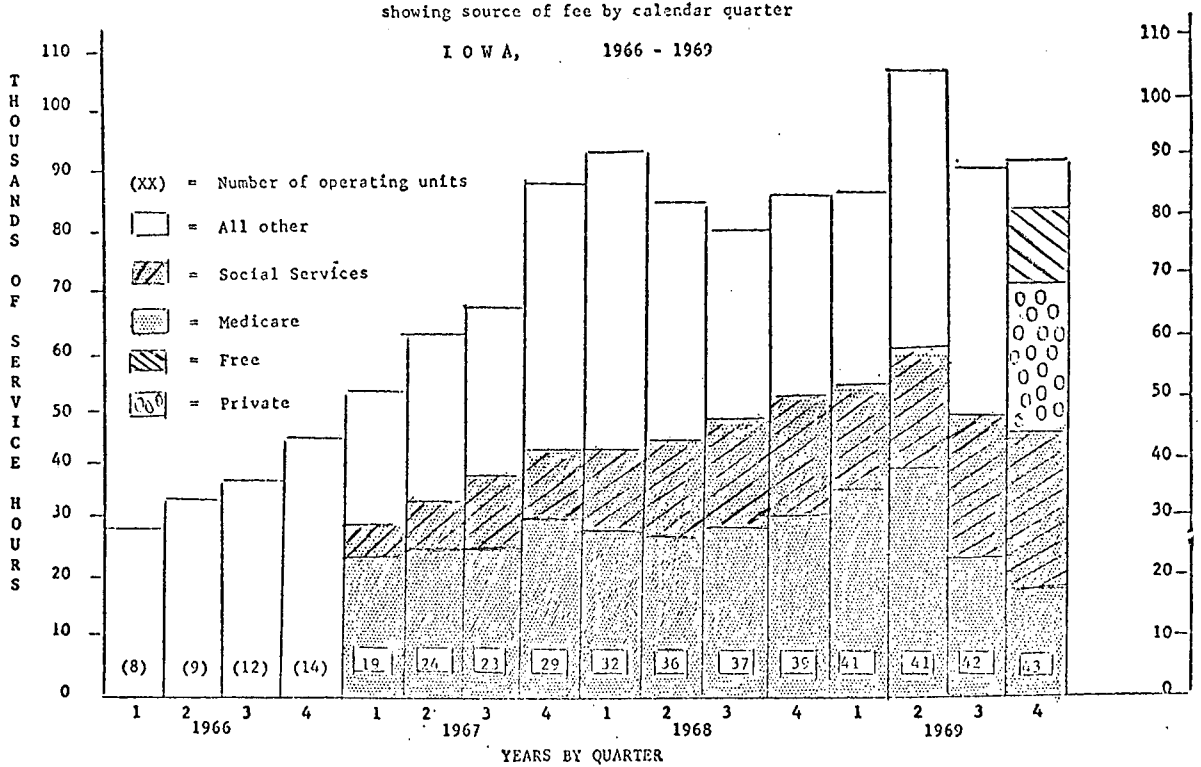
Total of beds: 3,083

Figure 1

HOMEMAKER HEALTH AIDE SERVICE HOURS

showing source of fee by calendar quarter

IOWA, 1966 - 1969



Recommendation 6.—It is therefore recommended that an interdepartmental coordinating body comprising representatives of the State Department of Health, the Department of Social Services and the Committee on the Aging be formed and given adequate financing and authority to promote, develop and establish comprehensive Home Health Care Programs in each section of the State. This should include developing adequate training programs for personnel who will staff such programs.

IV. FINANCING OF HEALTH CARE AND SUPPLY AND QUALITY OF HEALTH SERVICES[1]

The Task Force has reviewed "Toward a Brighter Future for the Elderly", the recent report of the President's Task Force on the Aging and finds that it concurs fully with the recommendations made in that report. The Task Force unanimously recommends including this material in its report. The following sections therefore, come directly from the President's Task Force Report and only the numbering of the recommendations have been changed to fit the present report.

"Medical care and the financing of that care are interrelated so sensitively that a defect in financing must carry with it implications regarding care. The Task Force sees that this concept is clearly illustrated in the Medicare program.

"The Task Force is convinced that:

". . . because out-of-hospital drugs are not covered under Medicare, some hospital stays are extended solely so that patients can obtain needed medication;

". . . because Medicare will pay for nursing home and home care only following a hospital admission, many elderly patients who could receive their diagnostic work-ups on an out-patient basis are needlessly occupying hospital beds;

". . . because Medicare limits coverage for health services provided in the patient's home, many older persons whose illnesses no longer require treatment in a hospital remain there longer than necessary or are confined in long-term care institutions;

". . . because Medicare does not cover early diagnostic and other preventive measures, many older persons neglect illnesses until they require expensive, remedial treatment;

". . . because Medicare coverage for stays in extended care facilities is limited to 100 days, there is a tendency to prolong hospital stays to use up hospital coverage, to discharge patients prematurely from extended care, and to force many older persons to apply for public assistance to meet the costs of nursing home care.

"The Task Force believes that such inadequacies in coverage under Medicare are driving up the costs of medical care for the elderly without commensurate improvements in the quality or availability of that care. These inadequacies will be further exacerbated as the number of older persons grows, and as the amount of chronic illness increases.

"Because the hospital is the most scarce and the most expensive facility in the community, the Task Force believes that sound public policy dictates the adoption of any measure which can reduce, without jeopardizing his health, the number of days an older person spends in a hospital. Reduction of one day in each hospital stay covered by Medicare in a single year (based on a $50.00 per day charge) would result in a savings of approximately $250 million for the Nation."

Recommendation 7[2].—"We, therefore, recommend that Medicare be modified to provide: 1) coverage for extended care and home care without prior admission to an acute care hospital; 2) expanded coverage for home care; 3) coverage of out-of-hospital drugs at the earliest date administratively feasible; 4) removal of the 100 day time limit on skilled nursing home care; and 5) coverage for early diagnostic and other preventive measures."

"The Task Force believes that, in addition to removing deficiencies in the financing of medical care for older persons, the government must act to expand the availability and improve the quality of that care. Three major concerns of the Task Force are: 1) demands unleashed by Medicare and Medicaid have placed existing medical facilities and personnel under enormous pressure; 2) paradoxically many older persons under-utilize existing health services because

---

[1] *Toward a Brighter Future for the Elderly, The Report of the President's Task Force on the Aging,* April 1970, pp. 30–32. U.S. Government Printing Office, Washington, D.C. 20402.

[2] Presidential Task Force Recommendation 11.

of lack of proximity to them, inadequate transportation, their medical ignorance, the formidable nature of hospitals and clinics, or their frailty; and 3) medical services more vital to the elderly than to the population as a whole, such as home health services, frequently are in short supply or do not exist.

"Less than a third of the Nation's certified home health agencies—of which there are fewer than 2,500—offer more than one service other than nursing care. Nursing home care is not only in short supply in most communities, but often is so low in quality that physicians are deterred from transferring elderly patients from acute hospital beds into long-term care. The result is too frequently the wrong care in the wrong place.

"The establishment of more neighborhood health centers, the Task Force is convinced, constitutes one effective and immediate means of dealing with these three concerns.[1] Neighborhood health centers are accessible. They are structured to be less formidable and confusing than hospital outpatient clinics. They also can serve as hospital outposts, bringing a full-range of hospital service into a community. An integral part of their staffing is the community health aide through whom the center reaches into the community. The community health aide's primary function is to surmount whatever barriers exist to the delivery of health services to residents of the area. Neighborhood health centers are particularly well suited to the delivery of preventive, rehabilitative, and home health services.

"If existing and new neighborhood health centers are to meet the health needs of the elderly, however, "seed" money will be required. The Task Force believes that a source for such seed money is front-end-financing from the Medicare Trust Fund. Front-end financing takes dollars which the Federal Government has collected for the reimbursement at a later date of services and uses a fixed percentage of them now to make certain that an adequate supply of those services will be available when needed. Because it expands supply and because it emphasizes prevention which can reduce demand, such financing clearly offsets in part the inflationary effect of Medicare purchasing power. The Task Force notes with interest that press accounts of the McNerny Task Force on Medicaid indicate a similar conclusion with regard to Medicaid.

Recommendation 8[2].—"We, therefore, recommend that the President seek Congressional authorization for front-end financing from the Medicare Trust Fund of a full range of geriatric health services including community health aides devoted exclusively to working with the elderly, transportation to and from health facilities, home care, and preventive techniques such as screening and health education.

"We further recommend that wherever possible these services be delivered through neighborhood health centers. We also recommend that a number of such centers be expanded through front-end financing from the Medicaid appropriation."

"In addition we recommend that in Iowa the requirement of relinquishing assets for eligibility for assistance be re-evaluated and realistically established so as to not impoverish the applicants and in essence cause them to declare themselves paupers, and that.

"Eligible applicants for extended care services receive adequate funds to cover the costs of the extended care service without taxing the self-pay patient."

V. PREVENTIVE MEDICINE AND REHABILITATION

In its survey of the health care needs of the aged, the Iowa Task Force found that Federal programs do not include preventive medicine. In fact, the doctor may not submit a charge for preventive medicine under a federally funded program. Private insurance programs also neglect preventive medicine. Patients have to be hospitalized in order to receive health services.

A survey taken in 1969 in the City of Des Moines by the Greater Des Moines United Way Planning Agency of those living in the downtown area in hotels and rooming facilities showed 50% in the 65–80 age bracket and 76% of those interviewed had less than $3,000 annual income; 88% lived alone; 50% had not had a physical examination in the past year; 78% expressed an interest in obtaining a general physical examination to stay well if such services could be ob-

[1] In using the term "neighborhood health center" the Task Force has reference to a type of facility. The geographical limitations which the Office of Economic Opportunity imposes on the centers which it supports are not implied. The Task Force hopes that all older persons will have ready access to such a facility.

[2] Presidential Task Force Recommendation 12.

tained. This indicates clearly that the elderly are not being given adequate preventive care. There is little doubt that preventive medicine is far less expensive than treating the illness at a later date.

Recommendation 9.—It is, therefore, recommended that the Ia. St. Health Dept. be charged to develop and implement a full range of geriatric health services including community health aides devoted exclusively to working with the elderly, transportation to and from health facilities, home care and preventive techniques, such as screening and health education, and including the provision of a regular medical checkup for the aging and the aged at a minimal cost, and without cost to those who cannot afford it.

This tends also to be true of rehabilitation. The Task Force finds that very little is being done in health care facilities to rehabilitate the aged. Most hospitals are not equipped and do not have the personnel to provide comprehensive rehabilitation services, and this is even more true of long-term care facilities. As a matter of fact, specialized rehabilitation programs are not readily available in Iowa. Even if such programs were available, however, there is a serious shortage of trained personnel in this field and their services are not adequately covered in insurance plans. Such programs "Remotivation Techniques" and other related programs should be given prime consideration.

Recommendation 10.—It is further recommended that any such range of geriatric services include the full range of rehabilitation services to be provided in whatever setting the aged may be; the only criterion being whether or not the service is needed.

VI. MENTAL HEALTH

Again the Iowa Task Force concurred fully in the recommendations of the President's Task Force on the Aging concerning mental health and unanimously includes this section as a portion of the present report.

"The Task Force believes that the limitations under Medicare for the treatment of emotional problems constitute an archaic throwback. Because the Task Force sees the resolution of the problems as an integral part of the total health needs of the elderly it advocated that every possible effort should be made to encourage the use by older persons of available mental health services. To that end it urges that Medicare coverage for the prevention and treatment of emotional difficulties should be reviewed and liberalized. The Task Force further believes that the range of problems associated with the provision of mental health care for the elderly constitutes a major public policy issue which requires positive and innovative Federal direction.

Older persons generally are reluctant to avail themseves of services for the treatment of emotional disturbances. They fear that to seek psychiatric help is the first step toward involuntary placement in a State hospital. Even those elderly who might be willing to accept out-patient care are frequently frightened away by the cost. This reluctance is unfortunate because expert opinion suggests: 1) that the incidence of emotional illness is high among older persons; 2) that emotional problems which many older persons regard as a natural part of growing old can be alleviated through outpatient care; 3) that for many older persons such care would involve only intermittent visits augmented by the knowledge that understanding sympathy and help were no farther than a phone call away; and 4) that without such care hospitalization may be unavoidable.

There has been recent trends toward the release of elderly patients from state institutions primarily because they are old. This policy is unsound for several reasons: 1) there is a lack of community services available to support these released patients; 2) there is a definite shortage of health manpower to care for these patients; 3) there is a definite link between adverse social conditions and the incidence of mental illness among the elderly.

Recommendation 11.—(*a*) It is therefore recommended that every possible effort be made for the utilization of existing mental health services by the aged with such needs; and

(*b*) that the special mental health needs of the aged be given full attention in state and local planning for the development expansion and location of comprehensive community mental health centers which should be as close to home as possible with minimal disruption of the patients family and community life; and

(*c*) that adequate services for the elderly mentally ill patients include short-term hospital care, long-term hospital care, day care, long-term residential care, foster home care, out-patient services, day centers and home visiting services; and

(*d*) that the local service of hospitals, county homes, nursing homes, mental health centers, and other agencies be coordinated to permit effective and appropriate care and treatment of the elderly mentally ill patient through all priate care and treatment of the elderly mentally ill patient through all

(*e*) that all non-hospital facilities such as long-term residential care facilities, foster homes and other homes for the aged be developed and maintained separately from hospital facilities for those patients who do not need further medical or psychiatric clinical treatment; and

(*f*) that the State Health Department be provided sufficient appropriation support and personnel to reexamine and expand its services relating to the licensing, inspection and regulations of homes in order to promote and insure the adequate

(*g*) that medical and psychiatric consultation services be made available to non-medical community agencies and organizations assisting in the care and treatment of the aged mentally ill.

"Medicare coverage of outpatient psychiatric treatment—50% of the annual cost or $250 per year, whichever is less—is so limited that it discourages older persons from seeking help and encourages practitioners to hospitalize older persons who may not require hospitalization so that they can receive treatment. Moreover the Task Force believes that the limitation on in-patient care in a psychiatric hospital—190 days during a person's lifetime—for those older persons who experience acute or recurring emotional disturbances is neither humane nor realistic. Nor is it medically sound if it results in the premature transfer of the older person after 190 days of treatment into a custodial care situation. It is also inequitable when compared with Medicare provisions for care of chronic or acute organic illness.

Recommendation 12[1].—"We, therefore, recommend that the restrictions in Medicare coverage on out-patient psychiatric care be removed so that Medicare pays the same benefits for out-patient psychiatric treatment as it does for all other medical care. We further recommend that the 190-day life-time limitation under Medicare for in-patient treatment in a psychiatric hospital be removed.

"In addition to examining the relationship of Medicare to the treatment of emotional disturbances of the elderly, the Task Force expressed concern regarding other problems associated with such treatment. These include: the use of State mental hospitals as custodial facilities for large numbers of chronically ill or disabled older persons who are not in need of active psychiatric care because alternative living arrangements with psychiatric consultation or support do not exist; the absence within many State mental hospitals or psychiatric services for those elderly patients who do require such care; indiscriminate regulation against the admission of older patients to public psychiatric facilities; recent trends toward release of elderly patients from State institutions primarily because they are old in the face of the absence of community services to support these released patients; manpower shortages; and the link between adverse social conditions and the incidence of mental illness among the elderly.

"Since all levels of government are increasingly active in this area, concentrated attention focused on the development of realistic and appropriate policies seems unwarranted. The Task Force believes that such matters were not adequately dealt with by the Joint Commission on Mental Illness and Health which was active during the late 1950's."

Recommendation 13[2].—"We, therefore, recommend that the President request Congress to authorize the appointment of a Commission on the Mental Health of the Elderly comprised of representatives from concerned Federal agencies, national organizations, Congress, and the judiciary, and private citizens to study, evaluate, and to recommend a comprehensive set of policies for the Federal government, the several States, and local communities to pursue in this vital area."

VII. DISSEMINATION OF MEDICAL INFORMATION

It has been noted variously that from time to time the elderly do not receive full benefits of programs available to them because they are not informed of the existence of such a program or service. An example of this was the original sign-up for Medicare which required a national effort, almost at a person-to-person level called "Medicare Alert" to seek out and find all of the eligible aged who had not gotten the word about Medicare.

---

[1] Presidential Task Force Recommendation 13.
[2] Presidential Task Force Recommendation 14.

The Iowa Task Force concurred in the President's Task Force Recommendation on Dissemination of Medical Information and unanimously made it a part of this report. This recommendation follows:

"Frequently community services are fragmented, dispersed, and confusing. Consequently, many elderly do not take advantage of such resources. To obtain a health service, for example, an older person must know of the existence of a clinic, where it is located, how to get there, when and how it functions, and whether or not he is eligible for it. The Task Force is convinced that communities must more actively insure that older persons are informed of and helped to utilize the resources to which they are entitled. Recommendation 18 proposes an innovative approach to delivering such information.

"While 'service programs' for the elderly are planned and financed at the Federal, State, regional, and local levels, 'services' are delivered in the older person's community. The Task Force believes that most communities need to deliver more services to their older citizens; at the same time the Task Force is concerned that older persons take full advantage of existing services. The elderly can only utilize those services, however, of which they are aware and whose method of operation they understand. Because the Task Force is convinced that the elderly and their families are entitled to knowledge of benefits, supports, protections, and opportunities which society intends them to have, it has searched for a new method of communicating information which is of concern to older persons.

"The Federal Government through its network of Social Security District Offices and their outreach stations comes into frequent contact with nearly all older persons. Information about community services could be disseminated in connection with such contacts. The opportunity here exists for a unique new partnership between the Federal Government and voluntary organizations in which the Federal role would be limited to the development of methods for the local dissemination of information to the elderly, financing, and evaluation of the quality of local operations. The voluntary role would be the operation of the system, at the local level.

"The Task Force recognizes that various kinds of information and referral services are already available to the elderly. It views the dissemination of information through Social Security Office as a means of expanding and augmenting existing information and referral services, not as a replacement for such services."

Recommendation 14[6].—"We, therefore, recommend that in addition to other community information and referral services the Social Security Administration establish a system for delivering information through its District Offices to older persons and their families concerning the availability of benefits and services for the elderly. We recommend that the costs of the system be paid from general revenues. We further recommend that, wherever feasible, the Social Security Administration contract for performance of this function with voluntary organizations. Finally, we recommend that in the performance of this function older persons be employed or utilized as volunteers on a priority basis."

VIII. RESEARCH IN HEALTH CARE

A. General

Most of the problems described in the foregoing sections of this report will never be solved unless research is done to determine the nature of the problems themselves and their possible solutions. Most of the research that is needed is of a long range nature. As was noted in the Introduction, the rapid industrialization of our society has led to a continuing increase in life expectancy, a growth in the number and proportion of aged people in our population, an imbalance in their geographic location, and the consequent emergence of many new and difficult problems.

In a number of the Recommendations already presented, reference has been made to the need for survey type research or other detailed investigations in order for us to have the knowledge and information on which to base action programs.

The Task Force finds that not nearly enough is known about the adequacy and appropriateness of health care services for persons in various age groups, to say nothing of the elderly.

In order to evaluate health-service needs in Iowa communities as an important factor in adjustment to aging, data will be needed about social and health agen-

[6] Presidential Task Force Recommendation 18.

cies, about the communities, and about individual persons at various stages of life—if not throughout the State—in a sample of Iowa communities. If done in a sample of communities, there should be a comparative study of data of health services in high and low senescity counties.

Recommendation 15.—It it, therefore, recommended that the Comprehensive Health Planning Council of Iowa be directed to conduct a Statewide study of health services available to the aged, and that the results of such study be provided to those agencies of government responsible for health care and to those educational programs responsible for health education.

It is further recommended that the State join with the Federal government if necessary to forward an expansion and development of both basic and applied research at the University of Iowa and other universities, colleges, training centers, official state agencies and volunteer agencies concerning all of the ways in which the present health care system might be improved to better serve the older segment of the population.

Again, as has been noted several times before, the Iowa Task Force found itself in complete agreement with the recommendation of the Presidential Task Force on the Aging, and recommended unanimously that the following section be included as a part of the present report.

B. Programs of continuing research

"The clear relationship between inflation in the cost of health care and Medicare and Medicaid gives urgency to the need for more study of how the Nation's health care system meets the health problems of the elderly. Recommendation 15 proposes a program of continuing research.

"The Task Force believes that the amount and range of health care which the elderly require and the ways in which that care is now financed sufficiently differentiate it from health care for the general population to warrant continuing attention to questions concerning the organization, planning, management, and delivery of such care. Two reasons for such a program are: (1) unless persistent health care inflation is controlled, the possibility of a backlash which may threaten the gains achieved through Medicare and Medicaid becomes real; and (2) to some degree evidence already exists of more effective means of organizing planning, managing, and delivering health care to the elderly; large scale testing to corroborate such evidence is indicated. The following are examples of the kinds of studies which the Task Force wishes the Federal government to undertake. They are not intended to be an exhaustive listing.

"Chronic and incapacitating illness, although not unique to old age, is the primary health problem of the elderly. The treatment of chronic illnesses requires an integrated chain of facilities and services—the community hospital, the rehabilitation center, the extended care facility, the skilled nursing home, the intermediate care facility, the neighborhood health center, outpatient and home care. Equally desirable would be the geographic concentration of these facilities and services. Grouping of long-term care facilities around a community hospital as part of a comprehensive health care complex (or, where appropriate, as part of a geriatric complex), would conserve the time of physicians and enhance the possibility of sharing other scarce professional manpower. The continuity of care would thereby be encouraged and the quality of care would also be improved.

"The absence of an umbrella of care while unfortunate for society as a whole, is particularly damaging to older persons. Constructing such a system, while expensive in the short run, will ultimately result in a reduction of costs. Moreover, it will allow physicians to make decisions based on what is medically desirable for a patient, not what is covered.

"The Task Force is concerned that Medicare and Medicaid, instead of encouraging the development of such an umbrella of care of the provision of the service which is indicated, have an adverse effect in the determination of the setting in which care of the elderly will take place or the kind of care they will receive. The Task Force believes that an alternative method of financing their health care—such as prepaid insurance which would cover the cost of a full range of care regardless of the location in which it was provided—can be designed to facilitate the delivery of comprehensive care. The Task Force also believes, however, that before a massive new initiative in medical economics is undertaken the Nation would be wise to invest in experiments, which, it is convinced, will demonstrate further that: 1) improvements in financing result in improvements in care; 2) costs are affected favorably by comprehensive

coverage; and 3) comprehensive coverage causes desirable changes in the lives of the elderly.

"Even before financing mechanisms are revised, existing Federal health programs, such as Comprehensive Health Planning, the Regional Medical Program, and Hill-Burton, can be used to bring into being a continuum of care for the elderly. The Task Force is convinced that more home care and more neighborhood health facilities would be developed if, for example, Hill-Burton applicants were required to give evidence prior to receiving a grant that they would assist in the development or expansion of home health services and/or neighborhood health centers. Similar incentives can probably be built into other Federal Health efforts. Here, too, the Task Force believes that experiments should be conducted on the effects of such incentives before such legislation is restructured.

"It also believes that a need exists for additional research to determine what the effect would be of removing or reducing all Medicare deductibles and co-insurance. Some Task Force members think that many older persons would abuse the scarce time of physicians if the deductible did not prevent them from so doing. Other members think that large numbers of older persons are already too reluctant to seek medical help without further barriers being raised in front of them. Additional questions concerning these features of Medicare which the Task Force raised are: How much serious illness among older persons is not discovered until it has reached a stage when it cripples or kills because of barriers to treatment raised by Medicare deductibles? Do deductibles and co-insurance actually reduce administrative costs? To what extent do they discourage demand. How much additional demand for health services would removal or reduction of these features generate? What do those elderly who pay deductibles and co-insurance sacrifice as a result in other aspects of their lives? Does their nutrition suffer, for example?

"In calling for more research the Task Force is not suggesting a series of small studies. An analogy to the kind of experiments the Task Force has in mind is the research on guaranteed incomes conducted for the Office of Economic Opportunity in New Jersey. The scale of that research is sufficiently "large so that OEO will ultimately be able to generalize about what would probably happen if a guaranteed income plan were adopted for society. While the cost of such testing is not insignificant, it will be far less expensive for society than engaging in massive change without anticipating its effects.

"An important precedent for delineating the health care needs of the elderly from those of the general population and devoting separate energy to their solution is the constellation of Maternal and Child Health programs formerly located in the Children's Bureau and now in the Health Services and Mental Health Administration, a component of the Public Health Service, which also contains the National Center for Health Services Research and Development. The Task Force believes that the National Center is a logical choice as the agency to direct the studies being called for."

Recommendation 16[1]. "We, therefore, recommend that the Health Services and Mental Health Administration establish within the National Center for Health Services Research and Development a Council for the study of the organization, planning, management, financing, and delivery of health care for the elderly. We further recommend that within a reasonable period of time this Council design, conduct, and report on large scale experiments concerning comprehensive coverage, incentives for comprehensive care which would be added to existing health programs, and the effect of removing or reducing the deductible and co-insurance features of Medicare."

ITEM 3. REPORT OF IOWA TASK FORCE ON HOUSING

INTRODUCTION

This housing report has been prepared in the interest of helping to develop for both Iowa and the nation comprehensive policies on housing for elderly citizens. In preparing this report, the Housing Task Force studied the present situation, and unresolved problems in some of the principal areas of housing

[1] Presidential Task Force Recommendation 15.

for the elderly in Iowa. The Committee has attempted to follow the specific charge given them by the Honorable Robert D. Blue, Chairman of the Iowa Commission on the Aging. This is the state unit that is entrusted with the responsibility of securing certain information for the National White House Conference on Aging scheduled in Washington, D.C., November 29–December 3, 1971. Where certain requested information on housing was not currently available, we have indicated this in the report. Much of our study dealt with the inventory of existing facilities, however, these were not examined by the Committee to try to determine their adequacy. There are designated state units which serve as inspecting agencies for certain facilities. This Committee has not attempted to sit in judgment on existing programs. Nor do we wish to use this report as a vehicle to promote personal causes. We have attempted to present a total state report.

Some of the available lists of housing facilities are quite extensive. The Committee felt that the report would have more impact and would be more widely read if it were somewhat condensed. Therefore, the state and federal sources of housing information in this report are listed in Appendix A.[1] The Commission on the Aging has an extensive catalog of these housing facilities that are summarized in this report.

Housing Problem Areas

Persons over 65 years of age constitute 12.5% of Iowa's population. This figure is well above the national average of 9.9%. These 345,000 older people often have limited budgets and face special housing needs.

For the most part, studies indicate that nation-wide there is a high interest among older Americans about being involved in the solution of their own problems, especially housing. The following problem areas play a relevant role in providing adequate housing for the elderly.

I. Transportation is a leading concern among the elderly. Poor public transportation causes a great inconvenience and even hardship in the everyday lives of our senior citizens. The transportation problem for the elderly may be defined by the following:

A. In the cities having public transportation, it is getting worse because of financial problems. Therefore, fares are increased to alleviate the cities financial burden, which in turn places an additional burden on families with low or fixed incomes.

B. In cities without public transportation, the elderly in many cases must depend on good neighbors and volunteers for transportation. This is not always available.

C. When the elderly lose their driving privilege, transportation becomes critical. This occurs either because of arbitrary age limits or inability to pay high insurance rates, though the individual is totally capable of driving.

As it relates to housing, transportation becomes a main factor in deciding housing locations of the elderly. Our senior citizens are compelled to locate near facilities and economic outlets which can service their needs. These areas often concentrate around the central or small business districts; though giving the elderly convenience and eliminating a transportation cost, their choice of housing locations is limited.

RECOMMENDATIONS

1. Since it is not always possible to provide housing for the elderly where transportation is readily available, a minibus type transportation service should be considered together with an elderly housing project, its operation to be insured by a transportation subsidy if necessary.

2. The present state law should be amended to allow, within the low rent housing project, retail outlets to accommodate the elderly tenants.

II. Loss of companionship is another deep concern to the senior citizen. The aged do not generally become involved in many worthwhile available programs because of no close companion to share the pleasures that come from group participation; and again many are unable to go to a central location because of lack of transportation, or the high cost of getting to and from the center of activity.

RECOMMENDATIONS

1. Housing for the elderly in low-population communities should be related to a community service facility for group activities.

---

[1] Retained in committee files.

2. Matters relating to the senior citizen should be removed from the many governmental divisions presently handling various problems relating to the elderly, and placed in the hand of a central agency. This agency should receive, assemble, study, and review all matters relating thereto, after which it would then recommend workable plans for federal, state, and local participation. These plans would include the provision of safe, decent, and adequate housing as well as ways and means the elderly could serve in the labor market, volunteer programs, education for the elderly, and working with youth groups. A single agency would be a vehicle of opportunity to provide a very cooperative and efficient means to meet the problems and needs of the elderly.

3. The recommendations of the President's Task Force on the Aging, especially as they relate to housing, should be implemented.

III. The population of Iowa has remained relatively stable for the last decade, but much movement within the state has occurred. A yearly average of 17,400 move from rural to urban areas. This means that many rural houses are left vacant, while new housing in urban centers is constantly being demanded. This trend in population movement also creates great difficulty for lower income families, especially the elderly, who desire to move from rural areas to small towns and cities, because there is no market for their rural dwelling.

With the rural to urban shift in Iowa (15%), both relocation problems and augmented financial problems occur for those elderly remaining in communities which are losing population in Iowa (about 40%). The problems of rural America are so serious that a strong and concentrated effort for rural development is needed, to meet these problems to slow down the population shift to the already over-crowded cities. One way to reverse this trend is to create an atmosphere in the rural areas that rural people wish to remain there, and for those living in the over-crowded cities to move to the rural areas.

RECOMMENDATIONS

1. To secure public housing for all communities, we recommend the establishment of *county housing authorities*, which could provide the necessary housing assistance to Iowa's multitude of rural communities as well as urban communities. Though this possibility exists according to law, there are currently no county housing authorities in Iowa.

2. For those communities choosing to do so, C.O.G. (Council of Governments) *housing authorities* could be established. This is another provision under Iowa law which has not been developed.

3. County, C.O.G., and current municipal housing authorities all provide for communities to handle their local problems with the least amount of interference from another agency. However, we also recommend the establishment of a state housing finance authority. It could provide both financial and technical assistance to local housing authorities and, if necessary, the *state housing finance* authority could serve as the local housing authority.

IV. According to the 1968 Statewide Housing study by the Office of Planning and Programming:

"Households headed by persons over 65 years of age constitute 22% of the total households in the state, far in excess of their 12.5% share of the population. This is mainly due to the smaller size of elderly households. 84% of all these households contain either one or two persons, while the average size for all households in Iowa was 3.19 persons in 1960.

"31% or 263,100 of all households in Iowa had an annual income of less than $3,000. However, 64% of Iowa's elderly households had incomes of less than $3,000. These persons therefore have limited funds available for maintaining or buying homes.

"Partially negating these income restraints is the high rate of home ownership among older Iowa residents. 80% of elderly household heads owned their homes, while only 69% of all household heads owned their homes overall. Since elderly households average fewer members, space requirements are not so great. However, space occupied by elderly households is virtually the same as the space pattern for all households, which average more members. Thus a greater strain is put on the budget of the elderly to maintain their households. There is a lack of smaller or more flexible facilities to accommodate the elderly. Unmet housing needs are especially evident in the towns and smaller cities. Interviews frequently brought out the desire of many elderly persons retiring from farming or other occupations to remain in the

towns and small cities near their former residence, but they were unable to find satisfactory housing which they could afford."

Therefore, a main objective in securing adequate housing for the elderly is "providing housing suited to the needs of older persons and at prices they can afford to pay."

RECOMMENDATIONS

1. Since most federal housing programs for assisting the elderly are structured to providing rental units, consideration should be given to assist elderly home owners who wish to remain in their own home. A subsidy, similar to the one available to renters should be provided. However, consideration should be given to all financial factors (e.g. maintenance, taxes, fixed costs). Obviously, a case by case assessment must be made for the practical feasibility of such assistance. With financial assistance, the elderly will be permitted to live in their own home rather than "forcing" them into a public low-rent housing unit, because of limited income.

2. If the elderly choose to live in a low rent housing project, the present state law should be amended to allow retail outlets within the housing projects to accommodate the needs of the elderly tenants.

SUMMARY OF RECOMMENDATIONS

1. A mini-bus type transportation service should be considered together with an elderly housing project, its operation to be insured by a transportation subsidy if necessary.

2. The present state law should be amended to allow, within the low rent housing projects, retail outlets to accommodate the elderly tenants.

3. Housing for the elderly in low population communities should be related to a community service facility for group activities.

4. A central office on aging should be established to develop national policy on aging; to oversee the planning and evaluation of all activities related to aging; and the coordination of such activities.

5. The recommendations of the Presidents Task Force on the Aging, as it relates to housing, should be implemented.

6. The establishment of county housing authorities and C.O.G. (Council of Government) housing authorities where feasible and necessary.

7. The creation of a state housing authority to provide financial and technical assistance to local housing authority.

8. Federal assistance to home owners.

The matter providing housing for the elderly citizens of the State of Iowa is a rather complex one. Housing is provided from many different sources, which include: the individual, the family of the individual, by agencies of the federal government, the State of Iowa, individual counties, and by the action of the governing bodies of local cities and towns.

Housing is largely provided for our senior citizens by the individual citizen themselves. Significant amounts of housing are furnished, however, by relatives of our senior citizens.

The new census should show the number of elderly citizens living in their own homes or living with a member of the family, as well as those living in institutions.

This census will reveal the type of housing furnished by individuals, and something about its age, and the type of utilities in this housing to furnish the basic needs for good housing and good health. At the time this report was submitted the census information was not available. Iowa has low priority on receiving this information from the census bureaus.

A substantial amount of housing is provided directly or indirectly by various agencies of the federal government. both through actual housing facilities or by financing housing programs.

Medical care is provided at the three veterans hospitals in Iowa. The patients are discharged when they recover. The hospital in Des Moines is operating at 358 bed capacity. The Iowa City hospital is operating at 456, and 1,200 is the bed capacity at Knoxville. These figures have been adjusted slightly downward. Aging is not a criteria for admission at these three hospitals. The only requirement is that they be a veteran.

Federal housing programs include loans to individuals and to organizations, profit and non-profit in nature, to custodial and nursing care.

The federal government. through the Hill-Burton Act provides grants for the building of hospitals and nursing care.

The Federal Housing Administration has four programs that can be directed toward the elderly.

Section 221(d)(3) is privately built housing for low-income families and individuals eligible for public housing and who are either dsplaced by government action, 62 years of age (or older), physically handicapped, living in substandard housing, or whose unit was damaged or destroyed by natural disaster.

Section 231 relates to housing for the elderly. This program has as its purpose the construction or rehabilitation of detached, semi-detached, row, walkup, or elevator type rental housing designed for occupancy by elderly or handicapped individuals—with eight or more units.

Section 232 helps finance construction or improvement of nursing homes and related facilities.

Section 236 is a program for rental and cooperative housing for low and moderate income families. This program, like all other subsidized programs could use more funds than are presently appropriated.

Section 23 is a program where local housing authorities lease existing units which are privately owned and are then sub-leased to qualifying elderly or non-elderly families. However, this is not an FHA program.

There are twenty low-rent housing agencies in managment in Iowa consisting of 2,257 units. Forty-five low rent housing agencies are in development in Iowa. These have 4,164 units in development for the elderly.

Consideration must be given to the fact that due to the fluent nature of the development of housing authorities, it is impossible to produce a rigid list as of any fixed date.

The housing authorities listed as agencies in management represent specific units presently occupied. Those agencies listed as housing agencies in development represent a wide range of specific conditions depending on whether the particular agency and project is in the stage of application, approval, funding or under construction.

There are eighty-one non-profit organizations in Iowa that have received loans for rural rental housing from Farmers Home Administration. These projects contain 498 units with an approximate cost per unit of $10,375. An estimated 800 people occupy the projects. Not all of these, however, would be senior citizens. Low to moderate income levels would prevail. The $45 to $90 per month variance in rent usually includes utilities.

The Small Business Administration is also involved in the private financing of nursing homes or related type facilities. They do have one restriction, however, and that is that all of the enterprises in which they deal must be for profit small business concerns. This does not preclude SBA personnel from becoming involved in assisting nonprofit organizations in the management areas. SBA has been involved in the private financing of twelve for profit nursing homes amounting to loans of $3,028,000. The bed capacity of these twelve nursing homes is 579, and they are about all full. In addition to the above, a facility in Keokuk with 120 beds is almost finished. The loan on this home is approximately $850,000.

The Housing Committee has attempted to study the Soldier's Home at Marshalltown, and the various state mental institutes regarding housing the elderly. It was learned that housing, as such, is not provided inasmuch as these are service oriented facilities. The possible use of presently vacant facilities at state mental institutes for housing for the elderly is unlikely. Changes in funding would be one of the problems involved. Those in state owned facilities cannot be receiving Old Age Assistance grants. A request has been made for information on the number of persons on Old Age Assistance who live in their homes or in the homes of relatives, and the number that the state provides housing for in some profit making or non-profit institutions not owned and operated by the state. However, we have not received this information to date.

Data from the Iowa study of AFDC mothers (Iowa Department of Social Services) support the assertion that "like the average American wife and mother, the mother on welfare in the Model Cities area overwhelmingly desires a single-family dwelling in which to raise her family" (1968:8). Nearly 90% of the mothers in this study preferred single family units. The condition of their present housing is reflected in a report of the Model Cities area showing that over half of the homes had been classified as unsatisfactory, but economically feasible to rehabilitate—while one-fourth of them were found unsatisfactory and not feasible to rehabilitate. A majority of these mothers said they would like to move or expected to move . . . they wanted more room, a better neighborhood, or help with housing problems. (A Review of Social Welfare Research).

Municipalities play an important part in providing housing for the elderly. There are twenty public housing projects in operation in the State of Iowa, with several more in process of development. As indicated earlier in the report, a substantial portion of the units are available for elderly people. There are 2,257 units in these public housing projects.

The Iowa Low-Rent Housing act authorizes all county, city, and local housing authorities to apply for and use financial assistance available under all provisions of the Federal Housing Act.

Iowa cities and counties are empowered to do the following:

1. Plan and carry out the removal of buildings from any slum areas and/or to plan, construct, and operate housing accommodations for persons of low income.
2. Undertake studies and analyses of housing needs and of the meeting of such needs and to engage in research and information on housing and slum clearance.
3. Determine where slum areas exist or where there is unsafe, unsanitary, or overcrowded housing and to make studies and recommendations relating to the improvement of these areas and substandard dwellings.
4. Issue tax-exempt bonds to be repaid out of project revenues for the above purposes.
5. Borrow money or accept contributions, grants, or other financial assistance from the federal government.

As permissive legislation, the Low Rent Housing Law gives Iowa communities sufficient latitude to make virtually any organizational arrangements to carry out public programs.

In the exercise of its public housing powers, the municipality must observe the following requirements concerning the design and operation of a low rent housing project:

1. Operation of the project on a non-profit basis;
2. Compliance with the planning, zoning, building, and sanitary laws of the locality;
3. Rental of accommodations to low income persons only;
4. Approval of the project by a majority vote in a local referendum. (Except for elderly and leased public housing).

The state of Iowa has had a law authorizing the county to build and operate county homes since 1851. Seventy-eight county homes are licensed custodial homes. Eight of these homes carry a dual license of both nursing and custodial; one county home carries a nursing home license only. Seventy-six county homes were built before 1957. The licensing state agency does not have records of the ages of these seventy-six homes inasmuch as certain state regulations did not exist prior to 1957. These seventy-six "old construction" county homes operate with 5,104 beds. Two county homes have been built since 1957. These "new construction" county homes operate with 276 beds. Two county homes are combination "old" and "new" construction homes having additions made to their facilities since 1957.

The exact census of these homes cannot be easily obtained. Each home is surveyed at least once a year and the number of residents is entered in the survey report. The estimated number of residents in these homes is 85–90% of the licensed capacity.

The type of people cared for in each of these licensed facilities is difficult to describe. A resident in a custodial home is a person who cannot function independently. This individual requires supervision at all times. He is the type of person that cannot leave the facility on his own initiative, must take supervised baths, cannot take medication on his own initiative, may have difficulty in negotiating stairs, and may need help in escaping from the building in an emergency situation. The residents of nursing homes, by definition, need supervision and some nursing care that can only be provided by a licensed nurse.

The Fire Marshals report on these County Homes show that about six do not operate with the sprinkler system due to water problems. Thirty county homes have a combustible classification. It is not possible to ascertain the cost of the housing per individual housed since seventy-six are old construction buildings.

There are seven communities in Iowa where nursing homes or custodial facilities have been built by municipalities in connection with munipical hospitals as provided by statute. These city operated facilities are connected with the Spencer Municipal Hospitals, Mary Francis Skiff Memorial Hospital at Newton, Murphy Memorial Hospital at Red Oak, Akron Hospital at Akron, Floyd Valley Hospi-

tal at Le Mars, Loring Memorial Hospital at Sac City and Virginia Gay Hospital at Vinton. There are 297 beds provided through these city operated facilities. There are other nursing homes owned by the municipality or local community, but which have no connection to municipal hospitals. There are eighteen nursing or custodial facilities in Iowa operated by counties in connection with a county hospital.

There are 89 non-profit nursing homes in Iowa with 5,416 beds. The average cost per day for a private patient in a non-profit nursing home is $11.79. This amounts to $358.41 per month. The average cost per day for a welfare patient in a non-profit nursing home is $8.51 per day. This amounts to $258.70 per month.

There are 405 proprietary nursing homes in Iowa with 16,455 beds. Private rates average $12.01 per day in proprietary nursing homes. This amounts to an average of $365.10 per month. Welfare rates average $8.77 per day, or $266.60 per month in these proprietary nursing homes.

A survey of the percentage of private versus welfare patients in these homes shows that in proprietary homes 49% are private patients, 45% are public assistance patients, and 6% of the beds are unoccupied. For the non-proprietary homes 75% are private patients, 24% are public assistance patients and 1% of the beds are unoccupied. The above breakdown on proprietary and non-proprietary homes come from a combination of sources.

Conclusion

Iowans have come a long way in providing housing for the elderly in recent years. However, much more remains to be done. Future progress will depend on the initiative of each one who reads this report.

ITEM 4. REPORT OF IOWA TASK FORCE ON EMPLOYMENT

In its deliberations, the Task Force agreed that there are certain rights and privileges to which our aging and aged citizens are entitled but, unfortunately, they are often denied.

The right to live in dignity, in comfort, and to continue to fulfill the inner drive to achieve, which is inherent in all of us, must be the major objectives of all concerned groups and individuals.

Service to the aging must be a total, all encompassing activity, structured to eliminate the arbitrary use of age as a barrier to participation in the affairs of the community.

Employment

The use of birth dates as a basis for hiring the working men and women of this country has been robbing the nation not only of highly qualified people but also denying these people a chance to contribute to the productivity of the country. Society must come to the realization that good workers are good workers, regardless of the number of candles on their birthday cake. It is the opinion of this Task Force that as we assist the older person to added knowledge and increased skills; to activity in community affairs, and to continued participation in business and industry, so we contribute to the total economy and the welfare of the nation.

The following report is respectfully submitted with the hope that it will serve, in even a small way, to implement improved and expanded services to older Americans.

The Task Force feels that the following items should be given consideration in the planning for services to the aging:

I. That services to older persons must be given on an individual basis. The problems and needs of older people are individual problems and needs. In the administration of services to these people, the tools and techniques used to resolve their problems and fulfill their needs must be individually determined. The Task Force is opposed to categorization or stratification of the aging in the area of their vocational worth.

II. Society, and particularly employers, must be made aware of the fact that evaluation of older workers must be made on the basis of functional age and not on chronological age. Arbitrary retirement requirements are serving only to force from the economy people who have skills, knowledge, ability and experience to offer to the employers of the nation. One man may be a youthful 70 while another is old at 50. Workers should be retired only when they are no longer

capable of producing competitively with other workers—not on a basis of age. To assume that when an individual reaches the age of 65, he becomes unable to work is ridiculous.

III. Training and retraining is feasible for older workers. Studies have proven, particularly those of the Graflex Corporation, that older workers can be trained and retrained as successfully as younger people. Perhaps the training techniques would be different but opportunities should be available for older workers to upgrade themselves vocationally or to acquire new skills.

IV. Pre-retirement Planning Programs must be extended and expanded to include workers in the service and labor areas. Training in planning for the retirement years has been confined almost exclusively to white collar and skilled workers. Ostensibly the greater need exists within the lower income groups and the semi-skilled or unskilled workers. People in the middle classes are programmed to organized activities to achieve a goal. Lower classes of people have never thought in these terms. They are not accustomed to planning ahead but have lived most of their lives on a day-to-day basis. Their relationships are most often within the family rather than the community. Therefore, this segment of society encounters retirement with no preparation.

V. Consideration should be given to the fact that employment means different things to different people and this should be incorporated in conference discussions. To some, it may be a need for full-time employment, for another a part-time job to supplement a pension income and, to others, volunteer work in his home community. But all older workers need activity, responsibility, and the opportunity to contribute to community concerns. Provision should be made for fulfillment of these needs.

VI. Discrimination cannot be eliminated by legislation. The mere fact that laws are passed by the Congress or by State Governing Bodies may serve, in a small way, to create a more favorable climate for employment of older workers. More intensive methods must be developed to convince the employer of the true worth of mature workers in business and industry and to dissipate the myths that exist. This will require the combined efforts of all agencies and organizations concerned with the problems of the aging.

VIII. That before employment of older Americans can be successfully accomplished, ancillary problems and needs must be resolved and fulfilled. A satisfied and efficient worker is one who can give relatively full attention to his job without the presence of such problems as inadequate housing, health problems, legal involvement, family pressures, or other conflicts to satisfactory job performance. This, also, requires united cooperative effort on the part of all agencies and organizations who can provide the needed services.

VIII. That Federal and State Agencies, Boards and Commissions must serve as the catalysts for publicity, public relations, education and communications. To achieve equality in employment for our elderly a sustained effort is imperative. Our objectives will not be quickly attained but will require continuing effort and continuous follow-up. Educational materials to influence employer and public attitudes must be produced. Training and retraining programs must be implemented and other services will be needed. The above-mentioned Agencies, Boards, and Commissions must assume the responsibility for action without relaxation through intensified services.

Summary

In studying the reports of the various community Task Forces, it was evident to this group that if adequate provision is made for the aging cooperation and combined effort will be required. We reiterate our contention that a broad definition of the term "employment" must be used. The reports make it apparent that the basic need of our aging and aged citizens is meaningful, productive activity—the need to achieve—the desire to continue to contribute to and participate in community life. This basic need must be fulfilled.

Our deliberations revealed that all of the problems of the aging are interrelated and that services to these people must be so directed. But we again caution the planners—you are dealing with individuals whose needs are individual ones. Planning must be done with the understanding that problems and needs are not the same in a rural area as they are in the urban environs. Therefore, no overall solution can be developed by a single group to resolve all of the problems or even the problems in one area—such as employment. The solutions must be derived from the combined reports of all the Task Forces.

ITEM 5. REPORT OF IOWA TASK FORCE ON EDUCATION

INTRODUCTION

As part of the Iowa preparation and participation in the 3-year plan of the 1971 White House Conference on Aging several citizens' Task Force groups were established to assess the current situation in selected need areas such as housing, nutrition, income maintenance and the like. The reports were also to identify major policy proposals to be considered at community, state and national levels. This is the report of the task force on Education for Aging.

Certain limitations affected the committee's composition, procedure and conclusions. These are identified here not in apology nor defensiveness but to permit the readers of this report to judge it by what it is—no more, no less. The committee chairman was selected and agreed to serve in December 1970. Under the conditions of no resources for support of travel etc., the selection of committee was confined primarily to those who had access to travel funds and were located primarily in the Des Moines—Ames area. Moreover, the report was due no later than March 31. Arrangements were completed and four people agreed to serve on the task force. The first meeting was held on January 21. Additional meetings were held February 2 and 16 and March 16.

The original charge to the committee requested a "compilation of reports on problems, needs and solutions" as background to suggesting "creative and innovative approaches and solutions". It will become evident that this report in no way attempts to exhaustively determine the problems, needs and solutions. Rather, we accept the general conclusions and observations of those who have studied these aspects of older Americans for some time. For an elaborate study we substituted some non-random sampling of ideas and experiences in education for the aging by persons involved in selected programs. Background materials from the National Conference office consistently arrived after our "last" meeting.

The report is presented in three general sections:

1. An overview of the current situation—Education and the Elderly
2. Approaches to the Development of Policy Proposals
3. Policy Proposals.

Some material which elaborates on the scope and need to consider education for the aging is appended to the report and is important background for the recommendations.[1]

AN OVERVIEW OF THE CURRENT SITUATION—EDUCATION AND THE ELDERLY

Since the first White House Conference on Aging (1961) there has been a growing awareness that while "getting older" is inescapable, how a person ages is something he can, with the help of his community and the educational system, influence substantially. In fact, aging successfully depends largely on education. Moreover, it may be said that the success of any community is measured by the way in which it meets the needs of its old, no less than of its young. While it is true that one's old age is in an important sense what one makes it, we now recognize that in our modern American society the community has a concomitant responsibility for creating conditions which provide the opportunity for older people to lead independent, mentally stimulating, and emotionally satisfying lives. Education may be considered as (1) what persons are motivated and qualified to do with their own resources and (2) what society supplies in the way of programs and facilities.

It is only comparatively recently that older adults have been thought of as having educational needs. Intellectual coasting for the latter half of life seems to have been the expected and legitimate course of events. However, since the early 1950's this ignoble characterization of late adult mentality has gradually changed, due to the increasing "visibility" of the elderly in our midst, and more favorable research findings relative to the capacities of older people. This change in attitudes and values, coupled with the fact that in the not-too-distant future a growing number of individuals may be spending up to 30 years or more in retirement, has been responsible for a fresh look at old age and the aging process. Moreover, it has pointed to education for aging as a necessary part of a lifelong learning process.

---

[1] Retained in committee files.

Certain other factors in our society have also added to the justification of special emphasis on educational needs of older adults. These include technological, economic, and societal changes since the turn of the century, which have altered roles, status and living patterns of older persons. Moreover, this is why the conservation, development, and utilization of the abilities and skills of older people, as well as their continuing need for self fulfillment, have, under the leadership of the Administration on Aging and related bodies, become increasingly a matter of state and national concern.

Education to meet needs of older people must also be developed in relation to facts in the current situation:

1. One of every 10 Americans is now 65 years or older (about one in 12 in Iowa). In aggregate, these persons have approximately 200 million years yet to live. Their numbers are increasing at the rate of 300,000 a year. How they live and what they do is of concern to society, as well as to them personally.

2. Yesterday's world was different. Older people face new challenges, within themselves and in their living situations, which make continuous education imperative. All aspects of life are now being affected by increasingly rapid socio-economic change.

3. Educational needs of older people vary with individuals. About one-fifth are functionally illiterate—at a time when the ability to read and write is virtually a must. The majority are faced with problems of sheer survival—income, health, housing and others. Those who could benefit most from education show the least interest in doing so. By and large, education has been reaching the middle and upper income class groups—the people who already possess sufficient resources to assure a relatively successful retirement.

4. How to prepare for serving others is a major challenge. Many older people feel useless and suffer from boredom to the extent it affects their health and all other aspects of life. Education can help them continue as vital and appreciated members of on-going society, effectively using their time and talents in activities that serve others. Such activities range from helpful visits of friendly persons to shut-ins and the many services of understanding grandparents, to the able elder-statesman contributions of persons like Benjamin Franklin (who, perhaps better than anyone else, personified the potentials of continuous education).

5. There are innumerable channels by which educational contributions related to aging are already being made, albeit at varying levels of activity and success. These include:

A. Iowa Commission on Aging established by government in 1965. Specified in the law are six functions. The fifth one has particular relevance to education:

"Cooperate with agencies, federal, state and local, or private organizations, in administering and supervising demonstration programs of services for aging designed to foster continued partcipation of older people in family and community life and to present insofaras possible the onset of dependency and the need for long-term institutional care."

B. Religious organizations from which older people don't "get retired". These function with all age groups: about the only place in our society where all ages are present at one time—and frequently. Clergymen serve, formally and informally, as pastor-counselors. Services are geared to the "whole of life". Wherever older people may live they have access to functions of religious institutions. Such have pioneered in establishing homes for retirees; also hospitals and activity programs in which the elderly participate. They are organized with leaders who can readily be contacted. Their state offices provide aids to these leaders—one of which is a digest of legislation affecting the lives of older people.

C. Television, radio, the press, books and library services—used extensively by elderly people.

D. Voluntary organizations—like the Federated Womens Club, Garden Clubs, Book Clubs, and others. These have departments with educational programs designed to interest the elderly and to help promote understanding of life in later years.

E. Retiree associations which provide services tailored to the interests of elderly people. Approximately five million older persons are members of two such organizations: (1) the combined (AARP) American Association of Retired Persons and (NRTA) National Retired Teachers Association and (2) the (NCSC) National Council of Senior Citizens.

F. Community schools with broad functions of providing education bearing on personal development and social concerns.

G. Area community colleges and vocational institutes which provide facilities and programs for adult education.

H. Universities and federally supported extension services which develop continuing education programs related to the needs of people.

I. Public agencies established for supplying particular services—such as those meeting the needs of low income people and the elderly.

This growing public interest in the welfare of the twenty million elderly people in our population requires that issues should be further clarified and effort intensified in three major areas: (1) education about aging, (2) education for older people, and (3) education by older people. Beginning about fifteen years ago there has been a steadily increasing emphasis on the first of these areas, through the press and other public communications media, research reports, and popular literature stemming from these sources. The second area has been slower in developing, but progress in this matter has not been negligible over the past ten years. Education by older people, though a more recent emphasis in the field of aging, has shown some dramatic and highly gratifying results.

Approaches to the Development of Policy Proposals

In theory, the state level task forces were to utilize the results from the community level hearings and conferences as one of the bases for identifying needs and policy proposals. This source was only partially useful to the education task force for two reasons. First, only a portion of the local hearings were available during the period of task force deliberation. Second, of those available (four), only one identified any needs, let alone solutions, in the educational area. This is not a condemnation of the planners or participants in the hearings, only hard evidence to support the primacy of felt needs related to such survival issues as health, housing, income and transportation.

An alternative approach to identifying educational policy proposals would have been to pursue the problems identified by the other task forces, (housing, income, etc.) for those subject to educational programming. This task force believes this step should be taken, but it could not be done simultaneously with the deliberations of the other task forces. Another approach to developing policy proposals would have been to survey the organizations and agencies of the type listed in the previous section to secure their perception of needs and solutions and then "superimpose" an educational strategy in a set of recommendations.

Alternatively the committee members used the framework elaborated by Dr. Jacobs (See Appendix A) for much of their discussion. By conceiving of the educational task as one of education about, for and by the aging we felt a series of recommendations could be developed which would reflect felt, unfelt and unmet needs. The recommendations herein are the current judgment of the committee as to priority policy needs. It is the objective of the committee that these be thoroughly discussed, challenged and modified through the State White House Conference on May 13. A followup meeting by the committee might be used to revise this report.

Though the charge of the White House Conference called only for policy proposals, the following proposals are prefaced by a statement of goals which seem to us to be necessary to give a context to the proposals.

Policy Proposals and Position Statements

Progress toward solution of many economic, social, health, and mental involvement problems of older persons is impeded by negative attitudes toward aging and old people, in particular. The task of educational institutions, agencies, and organizations is to help create the new image of aging and old age that research findings over the past two decades have shown to be abundantly justified.

Most states involved in the White House Conference of 1961 recommended strongly that educational programs for all age groups, emphasizing positive attitudes toward elderly people, be developed. The growing body of knowledge about aging will be of small significance to the nation, unless it is adequately disseminated to the general public. This can best be done through those agencies and institutions which make public and private policies concerning aging, and thereby do much toward creating the social climate which both affects people as they grow older and conditions the young for their own later years.

POSITION STATEMENT I

In order to minimize duplication in our state we recommend that the main planning body in the area of aging should be the Iowa Commission on the Aging. It should be the central coordinating agency, through which other educationally oriented bodies—Iowa Association of Homes for the Aged, churches, senior citizen centers, community organizations, associations of retired persons, public and private schools, area colleges, universities, extension, the Iowa Nursing Home Association and many others can best cooperate in the task of building a better image of aging and old age. The education which is needed in this area must consist of much more than conferences, workshops, and institutes, as important as these certainly are.

POSITION STATEMENT II

In keeping with the threefold notion of education about, for and by the elderly, the committee recommends that the education here envisioned must be made an essential part of a comprehensive program of continuing education, beginning at the earliest school age level.

A general goal that sets the context for all of our policy proposals is: to legitimize and promote for all older adults education about aging, education for aging and education by the elderly.

POLICY PROPOSAL I

Develop a coordinating council for education for the aging (under chairmanship of the Iowa Commission on the Aging) from among the several public and private institutions, agencies and organizations to give significant thrust and constancy in educational programming for the elderly.

Primary areas of emphasis in the development of education for the aging should include:

A. A Consumer Education program for the elderly.

B. A Public Affairs educational program which would increase the participation of the elderly in the society's policy formation process.

C. Developing skills of a secondary nature (e.g. recreation, hobbies, etc.)

Primary groups to be represented on the council would include: Inter-institutional committee on extension, Department of Public Instruction, Association of Retired Persons, Council of Churches, and the like.

POLICY PROPOSAL II

Encourage increased educational activity for the elderly through the development of grant programs under the older Americans Act (or other appropriate legislation) which would support programs and personnel in the area of education for the elderly. Emphasis should be given to programs which will involve the most difficult to reach.

POLICY PROPOSAL III

Give priority to action research which focuses on the evaluation of educational programs being tried—by educational and non-school organizations—with an aim toward upgrading the capacity to deliver effective programs rather than focusing the research only on the problems and needs of the elderly.

POLICY PROPOSAL IV

Develop direct support and/or incentives for all employers, public and private, of (say) over 100 employees to make preretirement planning a regular fringe benefit. Support should be given on a grant basis for institutions to offer such programs to those employees not covered by the above.

ITEM 6. REPORT OF IOWA TASK FORCE ON RETIREMENT

A period of retirement at the conclusion of a work career is the expectation of most Americans. For many, probably a majority, retirement is an unsatisfactory experience.

The number of retired people in the nation is growing. And a trend toward earlier retirement is apparent, raising serious question about the need for, and

perhaps the wisdom of, concentrating life's leisure almost exclusively in the later years.

Dissatisfaction of so many of the retired does not entirely escape the notice of those approaching retirement. Dread of retirement is widespread.

These twin problems deserve serious study, assuming the nation's goals include improving the well-being of its citizens.

The White House Conference on Aging, pilot programs on preretirement, and early studies on aging are an encouraging start in this direction. But it is unlikely that these alone will provide more than a promising beginning.

A coordinated program of study initiated by the federal government aimed at defining problems and possible solutions more clearly is needed.

Starting with the obvious need to make retirement years more satisfying, the accumulated experience and common sense of public hearing participants and task force members provide some more specific guidelines for policy and program formulation.

Each of nine major need areas of the aging are represented by a task force.

1. Income
2. Health
3. Nutrition
4. Transportation
5. Housing
6. Spiritual Well-being
7. Employment
8. Education
9. Retirement

If one accepts the fact that needs are more likely to be met in the presence of anticipation and planning, then pre-retirement planning encompasses all of these areas and extends over most of the pre-retirement years.

Used in this broadest sense, pre-retirement planning can do much to allay the fear of change which underlies much of the dissatisfaction with and dread of retirement.

Retirement practices should be examined. Chronological age is increasingly inadequate as a measure of a person's abilities at time of retirement. Perhaps other measures are in order.

Our customs of reserving large blocks of leisure time until retirement can be seriously questioned. It seems entirely reasonable that alternative means of harvesting the leisure made possible by modern industrial society could be more desirable. Such alternatives might include extended vacations as retirement approaches or sabbatical leave after a specified period of service.

It may well be that the "now generation" is already in rebellion, at least in part, because of excessive work orientation of America's "over thirties."

In the long run increased research and education may be the key strategies. Too little is known about societal change, rate of change, and adaptability of people and personality to change. That which is known is infrequently and inadequately communicated to the average citizen.

Leisure has received little attention in our work-oriented culture. Training for leisure—to enjoy it, to make it respectable—might well become a part of education policy and program as a part of pre-retirement planning.

So might teaching an understanding of changing roles a person can expect to play over a lifetime—child, adolescent, parent, grandparent, retired or aging. So might an emphasis on prevention (rather than treatment) in health, on the contribution of good nutrition to well-being.

Integrated into such role education would logically come coverage of the changing needs within each task force subject matter area.

Long range retirement planning—lifetime planning might be a better term—should be made a part of formal education.

In the shorter run, retirement fears become more pressing. In addition, many people are beyond the effective reach of early formal education programs. So additional programs, falling more within the scope of the recent efforts at pre-retirement planning, are also needed. Success of pilot programs in pre-retirement planning argues eloquently for further work in this area.

Pre-retirement planning can provide psychological benefits of association with others who face similar concerns and problems. The process of sharing may also broaden understanding of the many options available, permitting deliberate choices of a more satisfying retirement role tailored to individual need.

Particularly important among the concerns of retired and soon-to-be-retired persons is fear of inadequate income. With adequate income, options in other

areas are much broader in most other need areas. This is true even in retirement role, since society tends to regard income or wealth almost as highly as work.

From a practical standpoint, pre-retirement planning can anticipate income needs (including inflation) and examine available means of providing for them. In the area of health, an understanding of physical and mental aging processes, along with preventive emphasis is needed. Similar anticipation of and provision for changes in other need areas can help allay some of the fears of retirement.

Pre-retirement planning should be actively encouraged.

This policy might be implemented through such channels as adult education programs, private firms, educational television, the Social Security Administration, and packaged materials for self or voluntary group use. The federal government should initiate additional pilot programs on pre-retirement aimed at reaching various segments of the population.

Since adequate income is so important to a satisfying retirement and since so many of the retired have inadequate incomes, employment activity becomes a major concern. It also provides a role identification which fills a gap for some retirees.

Value placed upon work in retirement years is indicated by studies showing that the self employed who have financial resources for extensive options tend to slow down with aging rather than to retire completely. This may argue for a re-evaluation of customary retirement practices.

Those who are able to work, want to work, and need the income should be actively encouraged by federal government policy.

This might include special job placement assistance from the Employment Security Administration, lifting the earnings level at which Social Security payments are reduced, smaller reduction in Social Security payments for earnings up to a reasonable income level, reduction in minimum wage application for those who want to work at a slower pace, and removal of various inequities in determining eligibilities for participation in various programs.

Additional effort in this area can be made by other levels of government and by citizens groups. Kiwanis clubs and other groups have organized to find positions for which retired persons could qualify and to apprise those deserving to work of these opportunities. This is something the retired might even do for themselves.

The desire to feel useful and to participate in the community around them ranks high with many retired persons. Community service projects are nearly as respectable within society as work for pay, so this helps provide a role identification. For most, this is probably the nearest "meaningful equivalent of work."

Too often the question of the community is "what can we do for the old" not "how can we help each other."

Local communities must carry the responsibility for creative thinking on ways to use such volunteer workers effectively.

At present there is notable lack of coordination in volunteer programs. Nor is training offered for those who wish to serve but lack skills or understanding.

Neither have communities inventoried the talents and interests of citizens who would like to serve. It seems logical that some needs of both the retired and the community could be met in a sort of symbiotic relationship.

Such an inventory could be made a part of any community study of the needs of the aging.

Areas where population is sparce may offer more opportunities than first expected if open and innovative minds are applied to the search.

For example, there's little logic in maintaining a small town library open a few hours a week and another library in the local school. The two could easily be combined into a single unit with wider service. Community residents would be exposed to some of the excellent modern teaching materials. Some retired persons might serve as librarians, or acting librarians, with less cost and more tender loving care than is common in libraries at present.

The major government role in this area may be to disseminate ideas and suggested procedures for getting some of the early moves underway.

The need for recreational and social activities extends throughout life. Lack of income or health place restrictions on the options, but not on the need.

The income aspect could be helped by reduced price arrangements. Since many of the recreation facilities are in the hands of private firms, the reduced price approach will probably require much individual firm negotiations within communities.

Governments could call attention to the need and means for meeting it.

Public recreation—park entrance fees, fishing licenses, and the like—could be reduced for the retired or, perhaps, eliminated completely.

Reduced price public transportation could help make recreation and social activities more readily available to those retired on limited incomes.

Perhaps the same idea should be extended to adult education.

Many communities have started social and recreation clubs with considerable success. These are still not available to everyone. Nor have they employed enough innovative thinking in most cases.

Is there a need for midweek dances in "weekend" facilities with the type of music older people would enjoy? For informal discussion groups?

Government could help by promoting the idea and furnishing organizational materials to local groups or individuals who desire to start such clubs.

There appears to be a specific need for a drop-in type social center where retired persons are concentrated, especially low income retired persons. This would be a sort of wintertime park bench, a replacement for the crackerbarrel and pot bellied stove in the old general store.

There is need of some means for exchanging information among these clubs and centers so that good ideas of each are made available to others.

Benefits of such groups could be enlarged with some sort of visiting membership provision, perhaps with a "golden age" identification card to encourage interclub contacts. Newspapers might be persuaded to list club meetings and social centers as a public service.

Local government recreation specialists might be asked to help with early development of games, activities, and the like as clubs are getting started.

For those with more limited abilities or resources, other approaches are necessary.

Television, especially educational television, plays a part. The future here may just be opening up with the possibility of a library bank of video tapes that could be made available to the aging.

Some areas already have devised systems for making library facilities available through mobile units.

Some progress has been made in use of youth volunteers who visit the aging, read to them, play games, and the like.

There is a need for more instruction and equipment in the line of games and crafts.

Numerous retirement homes have done quite well in meeting the recreational and social needs of the aging with limited abilities. But such facilities are not available to many.

Much of the responsibility probably rests on the local community for meeting such needs. Government could play a vital role in dramatizing the need and sparking ideas for solutions.

The telephone can be used to meet some needs of individuals in their own homes. A daily call to check is continuing evidence that someone cares. Or a regular call from the retired person to a specified volunteer agency can provide security in knowing that someone will be out to check if the call is not made.

Some major problems of the aging overlap all areas of need.

For example, there's notable lack of coordination among the proliferation of government agencies attempting to serve the need of the aging. Certainly, another agency is not needed, but a coordinating function could be assigned to an existing agency.

A related problem is inadequate communication of the availability of such services to the population of aging people who are the intended recipients. One of the existing agencies, probably the one assigned the coordinating function, could take on this task.

There is a possible alternate for the information function. This could be assigned to a protective service unit which would also provide information on source, and perhaps estimated cost of private services

A protective service unit could be the clearing house which refers to an appropriate source inquiries on the whole range of problems facing the aging, especially those who have not learned how to use society's system.

For example, failure of a social security check to arrive on time can be a disaster to the poor. But the information on where to inquire about it may be lacking. Or someone may want to check on the location of Golden Age clubs. Or someone may question a sales pitch and wonder where to learn the facts necessary for evaluation.

Questions on medicare, health insurance, housing help, and a host of other subjects may need only to be referred to the proper agency or firm.

The protective service clearing house could be a volunteer function. But more logically, it seems a part of some level of local government.

In addition to the improvement of services to the retired, there should be more study, research and development in the field of pre-retirement planning to provide improvement in the attitude of those who have not yet been retired. This improvement in attitude and understanding can help to prevent retirement from becoming a traumatic experience and a source of sulky dissatisfaction to those who have retired.

With federal aid a good deal of preliminary work has been done in this field, although there is far more that needs doing. Responsibility can never be exclusive but the need for leadership by the federal government, one of the largest employers in the world and the operator of one of the world's largest retirement systems, social security, is obvious.

As Iowans we are able to point to one source of pre-retirement planning information which existed for three years at Drake University with the assistance of federal and state agencies. In this demonstration project, in which about 1,500 persons including pre-retirement groups from business, labor and government were involved, there were tentative findings as to effectiveness and method.

The annual reports of the Drake University Pre-Retirement Planning Center, its manuals and evaluation materials have been furnished to the Federal Departments of Labor and of Health, Education and Welfare and to federal civil service agencies. Some utilization of this material has already been had, in federal pre-retirement programs.

Drake University is continuing to provide guidance and service in the field of pre-retirement planning under its own auspices and has offered to assist the federal government in setting up an information bank to be centered at Drake to provide the latest data as to the amount and effectiveness of pre-retirement planning in the United States.

We believe that the further development of such pilot projects as the one which was created at Drake is desirable. Further knowledge is needed on rural and urban retirement problems, such as the differing availability of medical services. We need to know how to stimulate employment opportunities, how to allot the responsibility for pre-retirement planning between government, business, welfare and education.

Retirement is not necessarily the same problem for men and women, for the educated and the uneducated. A different approach may be needed for the person who will have $3,000 a year and the one who will have $35,000, yet each may have need for pre-retirement planning.

In the end it may be found that retirement is too personal a process to yield uniform answers helpful to everyone. Even if this is true, there still is value in suggesting helpful alternatives from which an individually satisfying answer may be obtained.

For this reason we believe that there should be, with federal encouragement, more pre-retirement planning and more research on what makes the best pre-retirement planning.

ITEM 7. REPORT OF IOWA TASK FORCE ON NUTRITION

POLICY RECOMMENDATION 1

The Iowa Task Force on Nutrition accepts the recommendation of the National Task Force on Aging, Recommendation 23 Nutrition Programs for the Elderly. "We recommend that the President direct the Administration on Aging and the Department of Agriculture to develop a program of technical assistance and, when necessary, financial assistance to local groups so that such groups can provide daily meals to ambulatory oder persons in group settings and to shut-ins at home."

DISCUSSION

In examining the incidence of malnutrition among the elderly, the Task Force concluded that insufficient income was only one of several causes. Other factors are loneliness, difficulty in getting to food stores, nutritional ignorance, and chronic illess. The Task Force believed that programs could be designed for older persons to provide adequate nutrition, combat loneliness, educate about proper nutrition, and give some older individuals a chance to do paid community service. Such programs could involve both private businesses and voluntary organizations.

Suggested means of reducing the incidence of malnutrition included: increasing cash income of older persons or the amount of food stamps; encouragement by the Federal Government of the development of local arrangements for social living for ambulatory persons in addition to home-delivered meals for shut-ins once a day. One way to accomplish this would be to allow older persons to use food stamps to pay for meals prepared by non-profit organizations.[1] This use of food stamps should not be restricted to shut-ins or older people who lack kitchen facilities.

The Task Force believed that all local programs should include, whenever possible, priority employment for older persons, education about nutrition, and ancillary services, such as recreation, health screening, transportation and dissemination of information concerning community services. Older persons, when able, would pay all or part of the cost of meals with the difference paid by the communities and/or Federal subsidy.

Policy Recommendation 2

It is recommended that a coordinating council on nutrition for the aging be developed under the Iowa Commission on the Aging.

DISCUSSION

It is logical that those concerned with nutrition be associated with an established functioning body. Such an arrangement should minimize duplication of effort and coordinate the programs of the various organizations concerned with nutrition for the elderly.

Policy Recommendation 3

Use ways to establish the concept that nutrition for the aging is a community health problem and prepare guidelines for community action. Give special attention to the nutritional needs of older persons living in small towns and rural areas.

DISCUSSION

It is only at the community level that the older people needing help can be sought out and identified. Often all that is needed is the direction of thinking to this area to stimulate action.

Policy Recommendation 4

Provide meals by a community agency rather than determining that the older people should move to an institution for the aged, when older people who live in their own homes or apartments are unable to provide adequate, nutritious meals for themselves.

DISCUSSION

It is highly desirable for older people to live in their own homes or apartments and maintain a considerable degree of independence and individual identity as long as it is possible for them to do so. For many older persons, a move from their own homes or apartments to institutions for the aged involves a difficult adjustment and it is usually more costly than living in their own homes or apartments.

Among the problems that may occur in providing their own meals, increasing food cost cannot be overlooked, but the most pressing problem may well be that of shopping for food when food stores are not within easy walking distance and there is no public transportation. This problem could be met by providing voluntary help and transportation for older people who need help in shopping for food. For those with inadequate incomes to purchase food, the Food Stamp Plan or some other form of subsidy could be provided, but there would need to be some effort to determine needs and then to see that needs would be met.

Another problem of some older people might be inadequate diet and food preparation because of lack of knowledge which could be partially alleviated through sound professional advice on simplified food preparation and the use of foods that could be easily handled. For those unable to prepare their own food, home delivered meals through a "Meals on Wheels" program or a service of that kind

[1] The Act, Public Law 91-671, Section 6. (h)—"The elderly person and his spouse may use coupons to purchase meals prepared for and delivered to them—by a private nonprofit organization" has been passed.

should be provided by some community facility or organization. A subsidy might be worked out for those unable to pay the price of home delivered meals.

An alternative to providing home delivered meals would be to serve meals for older people once a day at a central place in the community and provide round trip transportation for the older people as needed. Centers for this purpose in the community might include churches, school facilities, community centers, or recreation centers. One advantage of a service of this kind would be the social value of bringing people together. Many older people live alone and they have a great need for the stimulation of social contacts with other people. The cost of meals provided in this way could be subsidized for those older people whose limited incomes would not cover the cost.

Policy Recommendation 5

Use every means to develop an awareness and understanding of the need for voluntary leadership in the community in providing a variety of services for the elderly. Work with the Social Service Volunteer Services to coordinate the volunteer program.

DISCUSSION

Many community organizations including men's and women's service clubs, church groups, youth organizations and social clubs have, as one of their objectives, service to people in need. Some of their service objectives could be satisfied by providing specific kinds of help to the elderly. These might include transportation to food stores, Food Stamp Plan offices, church and local health facilities as needed. Another kind of service which is provided on a volunteer basis in some communities is a daily telephone call to elderly individuals. Besides giving the elderly person something to look forward to each day, the caller is able to find out whether or not the person is alright or may be in need of some special attention.

One of the universal human needs is a sense of personal worth, to keep one's "cup of life filled". This sense of personal worth is achieved not by service to one's self but rather by service to another person on a voluntary basis. This relationship gives the elderly person a sense of human dignity which is so lacking in the experience of many elderly persons. The person who voluntarily gives this service gains something of an intangible nature from the realization of being needed by another human being. There are more people available to give help than those in need and if the spirit of voluntary service to the elderly could be generated, the burden on each member of the community would not be great and the needs of the elderly would be satisfied.

Policy Recommendation 6

Develop special techniques and methods for nutrition education for the aging.

DISCUSSION

It is known that elderly people tend to have little motivation to develop new food habits and if they read, they rarely apply to themselves what they read. Professionals hand out pamphlets on diets which for several reasons are not followed. They do not take into account the living habits and patterns nor the available food and facilities of the person; they are written in an unfamiliar form and language; or there may be no motivation nor encouragement for the individual to follow suggested diet. Although it is an established fact that people learn less from lectures, this is the method used by many to give dietary information to the elderly.

One problem which appeared several times in the community reports, was the difficulty in preparing a good diet for one or two persons. There is a need and desire for help with the planning and preparation of balanced appetizing meals for one or two individuals. Family Food Aides of the Expanded Nutrition Program of Cooperative Extension Service would be well prepared and would be available to work in such situations. After the aides were given the necessary information and assistance from the professionals, they could help to adapt old patterns of buying and cooking to one or two member families.

Policy Recommendation 7

Support efforts to enact legislation proposing that sales tax money or bonus coupons be returned to the county for administration of the Food Stamp Program.

DISCUSSION

To acquaint people with the food stamp and commodity program, and to administer the program so it will reach those who need it the most, is an expensive process. In order to be adequately handled some source of income must be provided on a continuous basis. Since the money from bonus coupons can be easily identified, this is a logical source of revenue for the program.

POLICY RECOMMENDATIONS CONCERNING MAJOR QUESTIONS PROPOSED FOR CONSIDERATION BY THE NATIONAL NUTRITION SECTION OF THE WHITE HOUSE CONFERENCE ON AGING

ISSUE 1

Should the Federal Government allocate substantial funds for research on the influence of nutrition on the aging process and on the diseases of old age? Or should such monies be concentrated on action programs to rehabilitate the malnourished aged and to prevent malnutrition among those approaching old age?

POLICY RECOMMENDATION

A percentage of funds should be given to research to insure a continuing flow of knowledge. Money should be allocated to action programs to locate and rehabilitate the malnourished aged.

DISCUSSION

Since the influence of nutrition on the aging process and the diseases of old age is a relatively unexplored field, continued research is imperative. It is only through such study that effective action programs can be developed to help the coming aged and the population as a whole.

The malnourished aged need to be located and rehabilitated. They have made their contribution to society and should not be neglected.

ISSUE 2

Inasmuch as food and nutrition services are vital components of total health services, should the Federal Government move more forcefully to establish higher standards for the food services provided by institutions and home care agencies? Or, can the interests of the consumer be better served by demanding a higher level of performance of State government enforcement agencies where the primary responsibility for such regulation now lies?

POLICY RECOMMENDATION

The Federal Government needs to establish standards of food services provided by institutions and home care agencies, and insist that, in order to share in Federal grant programs, these standards be met. These standards must be enforced at the state level.

DISCUSSION

Supervision of nutrition services in institutions and home care agencies is essential. This should be a cooperative effort of Federal and State government. The requirements of the Federal Government for meeting high standards for sharing in Federal grant programs should serve as a pattern and goal for State requirements and regulations.

ISSUE 3

Should governmental resources allocated to nutrition be concentrated solely in the provision of foodstuffs to those in need? Or, should a substantial proportion of such resources be devoted to education of all consumers, especially the aged, about nutrition and to the education of those who serve the consumer in professional and related capacities?

POLICY RECOMMENDATION

Governmental resources allocated to nutrition should be used to alleviate conditions of the moment. Running concurrently with this, resources should be used to educate the consumer and those who serve the consumer in professional and related capacities.

DISCUSSION

Providing food for the poorly nourished does not guarantee that they will become adequately nourished. It is only through guidance, using all education resources and media, that the older people can be made aware of the importance to them personally of an adequate diet. There is a need for professionally trained and related personnel to have, not only special nutrition education, but training in methods of teaching effectively.

ISSUE 4

Should Federal Government policy for all Federally assisted housing developments for older people require meal services for group feeding of residents and for persons living nearby? Or, should the policy be to encourage provision of services and facilities for feeding within each household in the project (individual feeding) and for encouraging community agencies to provide for persons living in their own homes outside the development?

POLICY RECOMMENDATION

In general the policy should be to encourage provision of services and facilities for feeding within households. However, any large Federally assisted housing development for the elderly should have congregate feeding service which would be open to those living in the area.

DISCUSSION

If the individual is sufficiently motivated and has the ability to procure food and prepare food in his own home, a sense of independence and privacy desired by some individuals is attained.

However, since one of the major problems of older people is lack of transportation facilities, motivation, or physican capacity to reach food markets or group eating facilties, measures should be taken to alleviate these problems. For those who wish to remain in their own homes as long as possible, advantage should be taken of Home Health Service, home-delivered meals, and help be given with shopping and food preparation.

Another solution for those living in Federally assisted housing projects would be congregate feeding service open to those living in the area. An advantage of this might be to help to integrate the elderly into society preventing withdrawal, isolation so often resulting from living alone.

ISSUE 5

Should the Federal Government assume the responsibility of making adequate nutrition available to every American? Or, should this responsibility be left to the individual, his family, and/or to the private sector voluntary groups and State and municipal agencies? If left to other than the individual or his family, should the fulfillment of the obligation be based on the provision of money income or the provision of food, facilities, and services?

POLICY RECCOMMENDATION

We recommend that the responsibility for providing the means to obtain an adequate food supply fall to the Federal Government, where it is not possible on an individual or family basis.

DISCUSSION

We accept the premise that every individual in this country has the right to adequate nutrition. The reasons for inadequate nutrition are many and include lack of sufficient amounts of the right kind of food. and lack of knowledge about nutrition. Therefore, assitance needs to be given at all levels; local, state, and Federal, to educate and supplement when necessary to make adequate nutrition available to all people.

Emphasis needs to be placed on the procurement and wise use of commodity foods and Food Stamps.

ISSUE 6

Should there be considerably more governmental control of the safety and wholesomeness of our national food supply? Or, should this be chiefly a matter of private and voluntary responsibility, with government controls left about at its present level or reduced?

Policy Recommendation

With the increasing complexity of our society and the growing concern with environmental health, we believe that governmental control of the safety and wholesomeness of our national food supply will be increasingly important. We respect the role food industries perform in maintaining food quality and safety, but we believe that this responsibility cannot be left to the private sector alone.

ITEM 8. REPORT OF IOWA TASK FORCE ON TRANSPORTATION

The difficulty in obtaining transportation was second only to inadequate income as the most frequently mentioned problem by the Senior Citizens of Iowa. Whether these Senior Citizens lived in rural or urban Iowa, they all share in a common feeling that additional transportation was necessary for their security and for improving the joy of their retirement years.

The Need

Adequate transportation, while a basic need for all our citizens, is a more critical need for the retired citizen. The retired citizen is faced with a continuing inflation while on a reduced fixed income. The rising cost of vehicle ownership and operation combined with physical impairments, result in a decreasing usage of a personal automobile.

Since 97% of the total vehicle trips (Des Moines Metropolitan Area) are by passenger vehicle, the Senior Citizen is indeed faced with a major problem in solving his transportation needs.

The problem at times of need for "Emergency Transportation has an impact which threatens an individual's entire security. This "Emergency Transportation" is an essential service which must be made available to every citizen but is perhaps most critical to the Senior Citizen who lacks adequate financial resources. Incidents have occurred where ambulance service has been denied because of the lack of funds to pay for the service in advance. In many small communities, and in most rural areas, ambulance service is, for all intents, nonexistent.

The knowledge that one may not be able to obtain emergency ambulance service when a serious illness strikes, can cause emotional stress on a continuing basis.

While most Senior Citizens experience a degree of difficulty in obtaining tranportation on a day-to-day basis, observations by the Committee indicate that the matter was considered serious by approximately twenty per cent of the Senior Citizens. Almost without exception, the individuals with serious income deficiencies were the ones experiencing the most severe transportation problems. The restricted mobility of low-income Senior Citizens denies him the opportunity to participate fully in religious, social and recreational activities as well as causing difficulty in obtaining food and health care. The impaired mobility thus leads to increased loneliness and further isolation.

Goals

It would indeed be ideal if transportation could be made available to everyone including Senior Citizens on a demand basis. The cost of supplying such a demand service however, would be astronomical. A minimum goal which should be strived for is to provide "Emergency Transportation" to all citizens including Senior Citizens on a demand basis.

Transportation to meet the day-to-day requirements of the Senior Citizen on a restricted income, should be made available through mass transit or other public conveyance systems. The systems need not be restricted to use by the elderly, but should be designed to meet their transportation needs as effectively as possible. Factors to be considered in designing a system to meet the needs of the Senior Citizens includes routings, fares, hour of operation and equipment design. The systems considered should include taxi service as well as mass transit service.

Task Force Recommendations

1. Investigate the possibility of establishing emergency ambulance service as a part of a hospital's regular operation.

2. Require the establishment of a half-fare Senior Citizens program as a prerequisite for a transit system to be eligible for Federal Mass Transit Grants.
3. Require that all mass transit equipment purchased with Federal Grants in aid, be designed to permit easier loading and unloading by Senior Citizens.
4. Investigate potential of establishing with cooperation of social agencies, a special off-peak hour transit service on a periodic basis to serve day-to-day needs of elderly citizens in low-income areas.
5. Investigate the potential of requiring living facilities for the Senior Citizens developed under special Federal Programs to be located with access to a viable transit service.

Discussion of Suggested Federal Policies

This report is not intended to provide a record of the discussions and proceedings which led to formulation of the foregoing recommendations. The recommendations are presented as a starting point for the review of policies referred to the State Conference by the Staff of the National Conference. These referrals or revised issues for policy consideration are as follows:

POLICY NUMBER 1

Should the Federal Government adopt a national policy specifically aimed at providing transportation for the elderly, or should it be left to the State and local Governments and the private sector?

Task Force Recommendation

The Committee believes the Federal Government should adopt national policies designed to alleviate transportation problems of the Aged. The operation of such systems should be left to local administration within Federal guidelines.

POLICY NUMBER 2

Should the Federal Government provide for the development of transportation systems exclusively for the elderly, or should they be developed for all users regardless of age?

Task Force Recommendation

The Federal Government should provide for the development of transportation systems with special provisions for usage by Senior Citizens but available for usage by all users irregardless of age.

POLICY NUMBER 3

Should the Federal Government require that transportation be an integral part of any social services program for the elderly supported by Federal funds, or should transportation to these services be made a separate program?

Task Force Recommendation

Special transportation provisions for the Senior Citizens should be provided as a part of existing social and transit programs and not as a special program.

POLICY NO. 4

Should the Federal Government support the development of individualized, flexible transportation for the elderly, which would provide increased access to shopping, religious, social, recreational and cultural activities, or should this type of transportation be solely the responsibility of private enterprise and voluntary community action?

Task force recommendation:

The Federal Government should promote the development of periodic individualized service in cooperation with social agencies and to be provided by existing transportation systems or agencies.

POLICY NO. 5

Should the Federal Government support the development of programs designed to provide for the safety, comfort, and convenience of the elderly as a pedestrian, driver, and user of transportation systems, or should the responsibility remain at the State and local levels?

Task force recommendation:

The Federal Government should establish guidelines but the responsibility should remain at the State and local level where legislation affecting safety programs must be enacted.

CONCLUSIONS

The recommendations developed by the Task Force and listed in this report will not solve the transportation problems of the Aged. The recommendations however, if implemented, would provide a start in alleviating some of the problems of a portion of the elderly who suffer from a lack of adequate financing to meet their immediate transportation needs. The actual development of National Goals and Policies can only be achieved through a more thorough survey and analysis of the conditions which the Senior Citizen faces in his daily life.

ITEM 9. REPORT OF IOWA TASK FORCE ON SPIRITUAL WELL-BEING

As we begin to think about the spiritual well-being of the elderly, a few definitions seem to be in order. First, what do we mean by spiritual well-being? Second, who are the elderly?

When we move into the realm of the spiritual, definitions are hard to come by. No dictionary offers any help. But as there is evidence of physical well-being in a strong body, and economic well-being in a large bank account, there are certain attitudes indicative of spiritual well-being. We list a few: a sense of personal worth; a feeling that living is a purposeful experience; a certainty that life is worth the effort; an awareness of a power in the universe greater than one's own which enables one to face life with ultimate optimism; an assurance of some kind of immortality; a realization that one is part of a community; and a sense of human dignity. A person in whose life these attitudes are apparent enjoys spiritual well-being.

In some circles the elderly are considered to be those who have reached their 55th birthday. Business and industry in many instances have lowered retirement age to 55 years and the increasing difficulty for persons past 45 years of age to secure employment only emphasizes the fact that elderly persons are those who have passed their 55th birthday. However, for the purpose of this paper we are thinking of the elderly as persons 65 years and older.

In speaking of spiritual well-being, we must not too easily conclude that it is covered solely by what could be called loosely "one's religious experience" in terms of faith, beliefs, relationship to church groups, or such practices as prayer, Bible reading, meditation, tithing, fasting and observing the sacraments of one's particular religious group. These factors all have a bearing, but since spiritual well-being embraces all of life, all of life's experiences, good and bad, likewise determine the state of one's spiritual health. To talk about spiritual well-being without reference to physical well-being, family relationships, economic resources, mental attitudes, education and intellectual potential, employment opportunities, earning ability, personal temperament and other factors that are part of daily living is to guarantee failure in coming to grips with the spiritual needs of the elderly.

Let us try briefly to see how the above factors affect the spiritual well-being of the elderly for good or bad. The period in life beyond 65 is the time when physical deterioration becomes very real. The degree of deterioration differs in individuals, but it is the rare person for whom the physical tempo of life does not slow down at 65. Beginning with this "slow down" it proceeds until, for many, the result is advanced senility and physical disability.

This is likewise a time in life when one's economic life reaches a plateau or begins to decline rapidly. Retirement, with or without adequate pension, is inevitable, earning opportunities are very limited and then usually at minimum wages, inflation takes away buying power, if not actual dollars. With income reduced and inflation rampant, taxes continue to rise to the place where home owning becomes difficult, if not impossible. The alternative to home owning is usually poorer housing in rental units where inconsiderate landlords too easily determine the physical environment in which one's declining years are spent.

One's involvement in community life, service organizations, church activities decreases day by day, not always because one is unable to make a contribution, but rather because those responsible for such involvement thoughtlessly decide that those of younger years are more active, more able and more willing to participate.

By the time one reaches this place in life, families are scattered across the land with economic and social interests of their own. Too often contact with loved ones consists of an occasional letter or an all too brief visit. Friends, too, because scattered, physical disability and death the lot of many of them, further diminishing the opportunity for the affection and fellowship so necessary to a meaningful existence.

Any attempt to improve the spiritual welfare of the elderly is doomed to failure unless we are willing to deal realistically with all aspects of human existence and experience that tend either to enhance or degrade the life of the individual in his later years.

The spiritual well-being of persons is certainly one concern, if not the primary concern, of the church. Let us look first then at the church's responsibility to the elderly of its constituency. These are the persons who, through decades of devoted service, have served the church faithfully. Their families were reared in the church. For the most part, they turned to the church as the agency to impart religious instruction to their children.

These were the persons who supported the church, sharing their financial resources but also sharing their lives in service. They served on committees and commissions, official boards and as trustees; they taught Sunday School classes and sponsored youth groups, they sang in the choir and served as ushers. They served church dinners and suppers, they organized men's groups and women's groups, they participated in financial campaigns and evangelistic efforts. For them the Sabbath Day was God's Day, a day that in a real sense belonged to the church. The words of the old hymn, "I love thy church, O God, her walls before me stand, dear as the apple of thine eyes, engraven on thy hand," was not only a song upon their lips, but words written large upon their hearts. In short, these persons were the church; but now they are old.

Younger persons have taken over. The wisdom of the elderly is no longer sought, though their money is still welcome. Physical disability, infirmity, and lack of transportaiton make regular attendance upon the services of the church difficult, and the rich fellowship they once found in the church has ceased to exist. Even the family, which in early years they directed to the church, too often forgets how much the church means to those of declining years, and carelessness miss many opportunities to help these older persons enjoy the fellowship of the church. Each year finds more of this group confined to nursing homes, retirement homes, and hospitals where concern for their physical health supersedes concern for their spiritual health. A church which does not minister to this group is not fulfilling its mission as the Church of Jesus Christ.

How then can the church fulfill this mission to the elderly?

Certainly, being aware of their existence as part of the church's constituency. A simple questionnaire, explained from the pulpit and widely circulated through the parish, will quickly identify those of advanced years to whom the church should be ministering. If this can be an ecumenical effort, an entire community can be made aware of this responsibility. In addition to asking for names and addresses of older citizens for purposes of identification and location, a few other simple questions might well indicate the direction this ministry should take. 1) What are the basic spiritual needs of the elderly persons you know? 2) How do you see these needs being met by the church? 3) Do you know of unique programs for the elderly that could become part of your church's program? 4) Are you willing to have a part in a ministry of this kind?

Such a questionnaire would not only remind the church of its own elderly members and constituents, but more important, if circulated widely enough, would bring to the attention of the church scores of older persons who have no relationship to the church, but whose spiritual needs are even more desperate. To overlook this latter group out of concern for the former is to provide an inadequate ministry to "God's older children."

The pastor and his associates, if any, must see that this group is not neglected. When his schedule and strength permit the pastor to give personal attention to the elderly, he should do it. No ministry he performs is more needed nor will be more appreciated. Many churches, especially large ones, would be well advised to see that on their staff is a person, retired minister perhaps, or a devoted layman, whose primary duty centers in a ministry to the aging. Where this is not possible, a committee of concerned persons of all ages will find a satisfying field of service in seeing that the older members of the community are not cut off from the program of the church. The types of services rendered

by such a committee can be as numerous and as creative as human imagination can make them.

Visitation would have a large place in such a program. A visit on behalf of the church is "an outward and visible sign of an inward and spiritual bond" between the church and those for whom it has responsibility. Information gained in such visits will open many avenues of ministry for the church. Not only spiritual needs, but physical needs can be brought to groups within the church who can minister to these needs. Prayer groups and Bible study within nursing homes, retirement centers, and even in neighborhood settings will nurture the spiritual side of life. Among the elderly are many who need help in building a faith strong enough to sustain them as they meet illness, suffering and death. Such should be brought at once to the attention of the pastor who perhaps can best minister at this point.

Many older persons would not need this personal attention if able to participate in the regular services of the church. A lack of transportation prevents this participation. Here is a project ready-made for some group within the church. With a bit of planning and a few volunteers, many older people who sit alone in front of a radio or TV set on Sunday morning could be worshipping with a body of Christians in their own church home.

An occasional day of celebration for those older persons who have given so much to the church could well find its place in any church calendar. "Honor to whom honor is due," and to whom is more honor due in our churches than those who through the years have served the church faithfully and well.

Some medium of communication should be devised to keep the elderly informed of activities in the church, but also to keep them alert to community agencies and services that minister to their welfare. What is happening in health services for the elderly? What's new in Medicare and Medicaid? Social Security? Low cost housing? Employment for those still able to work? What is the legislature doing to help or hinder the elderly?

Any church with a secretary and a mimeograph plus a committee of concerned persons could keep its entire constituency, members and non-members, alert to events which have a bearing upon their welfare. Every contact the church can make with its older constituency, whether by pastor, parish visitor, calling committee, newsletter, parish paper, telephone call, helps dispel the loneliness that is detrimental to spiritual health.

We are not implying that the churches are neglecting their responsibility where the elderly are concerned. Indeed, the things suggested above are things which some churches are now doing. We mention them only in the thought that they may strike a creative spark for some group anxious to enlarge its services to the Senior Citizens of the community.

In many areas, the church has taken the lead in providing rest homes and retirement homes far superior to the facilities provided by the secular community. In many instances, this has been done by individual denominations, in other instances on an ecumenical basis. There is no reason to believe that the church's effort at this point will diminish. A valid criticism of many of these operations is that often the cost of such facilities makes it impossible for the "elderly poor" to enjoy such accommodations. The more affluent persons need good housing and are able to pay for it. The churches which meet this need are to be commended for what they are doing. However, a Christian commitment to minister to the older citizens of a community means that some way must be found to provide decent surroundings for those persons whose income makes it necessary for them to live alone in dingy, unattractive, one-room situations that negate any possibility of spiritual well-being. Here is a challenge to the church to come up with a program of low cost housing to meet this need. In the inner city are hotels that could be refurbished to make pleasant, clean decent living quarters for those unable to afford plush surroundings. Here is an opportunity for churches of a community to band together in an ecumenical effort in providing this type of housing. Government funds are available, or could be made available, to help finance such an operation.

Few things destroy the spiritual well-being of the elderly more than a feeling of uselessness. Many older citizens would welcome a chance to serve the church within the limits of their ability to do so. Many churches call upon such persons to help with the church's mailings, the preparation of bulletins, to care for minor repairs about the church property, to care for shrubbery and lawns that make the church more attractive. Groups can be brought to the church for social purposes where they provide their own entertainment. Many Senior Citizens

Groups center in churches that have made their facilities available for such purposes. The wise minister will call upon his older members for counsel and advice. Such activities as these bring a sense of worth and dignity to individuals who participate and contributes to their spiritual well-being.

The church that would provide a complete ministry to the older citizens of a community must be aware of the agencies and services other than the church which offer help in such a ministry. Social service agencies, for example, have much to offer the senior citizens; public health agencies; service clubs; women's groups in many instances stand ready to make valid contributions in this area. With the increasing spirit of cooperation among the denominations, ecumenical program of service to the elderly could work wonders. National and state legislatures must be made more sensitive to needs of the elderly. Where better can such enlightenment come from than from a group of interested churches deeply involved in such ministry.

With churches becoming much more aggressive as "agents of change" where legislation is involved, is it not conceivable that churches would be within their right to bring pressure to bear upon legislatures in the interest of this large and too often forgotten group of citizens?

Legislation alone is not the answer, but government can do much to improve conditions more favorable to the spiritual well-being of the elderly. Issues which might well be brought to the attention of legislative bodies include: (1) job discrimination because of age; (2) adequate health care insurance; (3) increased social security benefits; (4) mass transportation; (5) tax relief; (6) adequate housing; (7) counselling centers; (8) pre-retirement planning services; (9) funding of programs designed to benefit the elderly in numerous ways.

In this presentation we have endeavored to confine our consideration to factors that have a bearing upon spiritual well-being. Our suggestions are by no means thought of as all-inclusive, but rather suggestive. While many of the factors discussed herein touch community and governmental agencies beyond the church, they all in one way or another are factors that contribute to the spiritual well-being of the elderly. We have tried to make plain the ways in which the church can continue and improve its ministry in these areas while acknowledging the church's dependency upon community and governmental agencies for the fulfilling of a complete ministry of spiritual enrichment for the elderly. Without the church to lead the way, without community and governmental groups to lend a hand, many of the elderly can never know true spiritual health. With those groups cooperating, spiritual well-being becomes a possibility.

We plead for this kind of cooperation for the sake of this large group of older citizens.

Appendix 2

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

If there had been time for everyone to speak at the hearing on the White House Conference on Aging and related matters, in Des Moines, Iowa, on May 13, 1971, I would have said:

The following replies were received:

MARY I. DAHL, CEDAR RAPIDS, IOWA

I certainly would like to see 100% benefits paid to the widows of the Social Security beneficiaries—that is 100% same as the husband was drawing.

I also would sure like to see Medicare lowered on age one can start benefits. I am a widow age 60, and 5 years more seems a long time away. If I should come into a long illness, as my hospital insurance isn't very much and if one does have a small savings it would sure be wiped out. Even 62 age would sure help. We need some kind of health insurance for people that isn't covered yet by Medicare, or don't have husbands that carry group insurance where they worked. If you have a little too much in savings or pension you can't even get Medicaid. So many widows that are widowed at 60 (or little before as I was) will take their pensions (as I did) and still a long ways from Medicare. I am sure in hope that mass transportation can become a reality as this is awful the way the Senior Citizens have to beg and ask and wait and humble and almost crawl to get a ride anywhere or anyplace and it is as you know for a fact that younger people and also middle age want the seniors to just get lost—period. That is why we seniors sure need help in Transportation, Health Insurance and Medical for doctors and Recreation some place that we know we are wanted with people our age. We do have some here in C. R. but need more outlets. I am thankful for the raise we are going to receive in June and thank the Senators that voted for it. Keep up the good work and we will be ever grateful for the help we do get.

Respectfully, thanking you.

JOSEPH M. BALDERSTON, DES MOINES, IOWA

At the inception of the Social Security Program, it was envisioned that ultimately as the program matured the extension of coverage would include all the elements of our society who might be affected by adverse circumstances. Despite this intent of the early planners of the Social Security system, we are still after 35 years providing services to people in need on a piecemeal and inadequate basis. With the pressures of our present economy, shouldn't we be giving some thought to eliminating the earnings from any consideration? Presently, persons over 72 have this privilege. In view of current living costs, shouldn't we now extend this provision at age 65?

Persons over 65 who are dependent on Social Security should have the privilege of working to the extent of their capacities to do so. The overall effect of the lowering of the provision for exempting earnings after age 65 from consideration would be to maintain total income of those over 65 at a more appropriate level for meeting the cost of living requirements. Another distinct advantage is to provide the older person an opportunity to acquire some financial cushion against his later

years. The maintenance of income at a higher level is a much needed asset for those older Americans in the lower income brackets. I would recommend reducing the age requirement for benefits regardless of the amount of earnings.

Conservation of the trust fund by discontinuing the practice of making loans from trust funds at reduced interest rates should be one of the provisions given legislative attention. A reasonable rate of interest ought to be comparable with that paid on savings bonds or that rate established by the Federal Reserve.

Undoubtedly, the most devastating practice of the Social Security system is the lack of "Pass Along" provisions in the legislation governing payments of categorical assistance where the recipient is dependent upon one of the categorical programs in combination with Social Security retirement (or disability) cash benefits. Far too often increased Social Security legislation to increase benefits to needy individuals is not passed along by the states. Old Age Assistance checks are reduced in the amount of the Social Security increase. State funds are then available for other programs at the expense of the under-privileged and elderly Americans. "Pass Along" provisions should be included in all legislation increasing Social Security benefits to insure receipt of the benefit by the individual in whose name the increase is legislated for. Let's quit the illusion-creating farce of supposedly helping the needy recipient while in actuality placing the additional funds in state treasuries.

Your interest and action on these recommendations will be appreciated.

○