95TH CONGRESS
2d Session

SENATE

REPORT
No. 95-771

PART 1

DEVELOPMENTS IN AGING: 1977

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 78, FEBRUARY 11, 1977, AND
S. RES. 147, JUNE 14, 1977

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

TOGETHER WITH

ADDITIONAL AND SUPPLEMENTAL VIEWS

APRIL 27 (legislative day, APRIL 24), 1978.—Ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE
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SPECIAL COMMITTEE ON AGING

MEMBERSHIP, FEBRUARY 1, 1977–MARCH 31, 1978 [1]

FRANK CHURCH, Idaho, *Chairman*

EDMUND S. MUSKIE, Maine
LAWTON CHILES, Florida
JOHN GLENN, Ohio
JOHN MELCHER, Montana
DENNIS DeCONCINI, Arizona

PETE V. DOMENICI, New Mexico
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CHARLES H. PERCY, Illinois

WILLIAM E. ORIOL, *Staff Director*
DAVID A. AFFELDT, *Chief Counsel*
LETITIA CHAMBERS, *Minority Staff Director*
GARRY V. WENSKE, *Assistant Counsel for Operations*

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[1] Amendment No. 23 to S. Res. 4, Reorganization of the Senate Committee System, agreed to Feb. 1, 1977, established the Special Committee on Aging as a permanent, nonlegislative committee under the rules of the Senate. Membership was reduced from 23 to 14 for the 95th Congress and by attrition must begin the 96th Congress with no more than nine members.

LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., April 27, 1978.

Hon. WALTER F. MONDALE,
President of the Senate,
Washington, D.C.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 147 agreed to June 14, 1977, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1977, Part 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing, and, when necessary, of obtaining care and assistance." S. Res. 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

Therefore, on behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

FRANK CHURCH, *Chairman.*

SENATE RESOLUTION 78, 95TH CONGRESS, 1st SESSION [1]

Resolved, That, (a) in holding hearings, reporting such hearings, and making investigations as authorized by sections 134(a) and 136 of the Legislative Reorganization Act of 1946, as amended, in accordance with their jurisdiction under rule XXV of the Standing Rules of the Senate, the following standing committees are authorized from March 1, 1977, through June 30, 1977, in their discretion (1) to employ personnel, (2) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel of any such department or agency, and (3) to make expenditures from the contingent fund of the Senate, as follows:

* * * * * * *

SEC. 2. * * *

* * * * * * *

(c)(1) In carrying out its duties and functions under section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4, 1977, the Special Committee on Aging is authorized, from March 1, 1977, through June 30, 1977, to expend from the contingent fund of the Senate not to exceed $191,000, of which amount not to exceed $7,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended).

(2) Section 104(a)(2) of S. Res. 4, Ninety-fifth Congress, is amended by striking out "and for purposes of sections 133(g), 134, and 202 of the Legislative Reorganization Act of 1946,".

* * * * * * *

SEC. 3. (a) The amount made available for each committee under the first section and section 2 of this resolution shall be added to the amount which was made available for such committee by resolution for the year ending February 28, 1977, and which is unexpended at the close of February 28, 1977, and such total amount shall remain available for such committee through June 30, 1977 (or, in the case of the temporary Select Committee To Study the Senate Committee System, until its expiration).

(b) Amounts authorized to be expended from the contingent fund of the Senate under this resolution by each committee shall be paid upon vouchers approved by the chairman of such committee, except that vouchers shall not be required for the disbursement of salaries of employees paid at an annual rate.

* * * * * * *

[1] Agreed to Feb. 11, 1977.

SENATE RESOLUTION 147, 95TH CONGRESS, 1st SESSION [2]

Resolved, That the Special Committee on Aging, established by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4 (legislative day, February 1), 1977, is authorized from July 1, 1977, through February 28, 1978, in its discretion to provide assistance for the members of its professional staff in obtaining specialized training, in the same manner and under the same conditions as a standing committee may provide such assistance under section 202(j) of the Legislative Reorganization Act of 1946, as amended.

SEC. 2. In carrying out its duties and functions under such section and conducting studies and investigations thereunder, the Special Committee on Aging is authorized from July 1, 1977, through February 28, 1978, to expend $432,000 from the contingent fund of the Senate, of which amount (1) not to exceed $50,000 may be expended for a study or investigation of health related issues, (2) not to exceed $20,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (3) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such Act).

SEC. 3. The committee shall report its findings together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 28, 1978.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required for the disbursement of salaries of employees paid at an annual rate.

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[2] Agreed to June 14, 1977.

PREFACE

Inexorably, the United States is "graying." This annual report by the Senate Committee on Aging can announce, in fact, that the common statistical assumption that every tenth American is 65 years or older is no longer true. It is now one in every nine Americans.[1]

This landmark indicator occurs at just the time that news media and governmental agencies are increasingly turning attention to the social and economic impact of an aging population. Often, such recognition has a negative tone. There is talk of sharp increases in "dependency ratios"—or relationship of workers still in the labor force to young and older persons who are not—and the "burden" of increasingly higher health care costs, particularly for long-term care of those in the highest age brackets.

Often a fear reaction occurs; intergenerational conflict can and has already resulted.

But this committee has also heard testimony emphatically stating that added years of life for our populations of today and the future are not so much a threat as a triumph.[2] Extensions of longevity are victories over disease and other ancient enemies, but only if they are accompanied by better quality of life.

Secretary of Health, Education, and Welfare Joseph Califano made that point in a recent speech raising "questions for the four-generation society"[3]:

> Indeed, it is wrong to view the maturing of the American population and the "graying" of the Federal budget simply as a problem for our society.

The Secretary added:

> We should remind ourselves that support for older Americans is support for *all* Americans. When medicare pays an older citizen's hospital bill it protects that family's savings, to pay for college tuition, or a new house, or their own retirement.
>
> *And "the elderly," we must remember, are ourselves—and our children. When we discuss the elderly in 2025, we are discussing the high school seniors of today.* (Emphasis added.)

This realization—that successes in overcoming aging-related problems extend far beyond any single generation—is coupled with the challenge that failure to deal with those problems will compound the difficulties later on.

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[1] For documentation and comparison with past and projected older American population levels, see pp. XV–XXXIII of this report, a demographic analysis by Herman Brotman, consultant to this committee.

[2] See, for example, statements of Senator Pete Domenici and National Institute on Aging Director Robert Butler at a hearing on "The Graying of Nations: Implications," Nov. 10, 1977, Washington, D.C.

[3] Title of a speech before the American Academy of Political and Social Science, Philadelphia, Pa., Apr. 8, 1978.

Similarly concerned about the need for action on a number of fronts related to aging, the Senate Committee on Aging in 1977 attempted to turn congressional and public attention to fairly immediate issues which have long-range implications, including:

—The desperate economic situation of millions of older Americans (see chapter II for latest available information on income levels) still living in or just above poverty despite implementation of modest improvements in the supplemental security income (SSI) program.

—The harsh impact of rising energy costs upon retirement income (see chapter III) and the growing fear that many older persons will be forced from present quarters if utility costs continue their rapid rise.

—The need for improvements in the food stamp program as another step towards adoption of a more rational and effective welfare program for low-income elderly and others.

—The need for action in strengthening the financing of our social security system, culminating in congressional efforts intended to take long steps toward that goal but which raised questions about whether additional adjustments may be needed.

—In rural and urban centers, the special problems of minority group elders.

—Lingering and disproportionate long-term unemployment and discouragement among middle-aged and older workers, despite a general economic upturn.

—The high cost of health care to many elderly persons, caused in part by the stubborn "tilt" of medicare and medicaid toward costly institutional care instead of in-home or outpatient services of one kind or another.

—Fragmentation of health and social services and efforts to reduce part of this problem through improvements to the Older Americans Act, due for extension in 1978.

Not every committee initiative resulted in legislative achievement in 1977, but there was significant progress on several important matters, all discussed in this report.

Perhaps the most striking success story in aging during the past year was the enactment, in both Houses of the Congress, of legislation meant to challenge mandatory retirement practices. The House Committee on Aging made an impressive case for change at hearings; the Senate Committee on Aging helped with a new report [4] and in individual legislation by several members. The final victory was tied to the Age Discrimination in Employment Bill. Although it still leaves gaps in protection, it is a splendid affirmation of the principle that individual older persons, like individual younger persons, must be dealt with on individual terms. Blanket cutoff points for employment, based on age alone, rob older persons of a basic protection. The new law provides new protections, but now additional questions arise. For example:

—How can part-time work become more feasible and available for those who no longer want full-time work but who don't want full retirement, either?

[4] "Recession's Continuing Victim: The Older Worker," prepared by Marc Rosenblum, consultant.

—How can practical and up-to-date "second career" training be made more generally available? How can we encourage greater access to other educational opportunities throughout the lifespan?
—How can we better assess the probable need for greater participation of older persons in the work force in a few decades, when the proportion of younger persons begins to decrease markedly?

Mindful of the challenge to which retirement policy in the United States will now be put, Senate Committee on Aging members are preparing for hearings and related studies related to readily apparent, or emerging, issues related to the rapidly changing age distribution patterns of this Nation. We will put special emphasis on increasingly outmoded assumptions about work opportunities throughout the lifespan.

A second immediate issue with far-reaching implications is the incongruously lopsided allotment of public moneys to institutional care when other forms of care might be less costly and more appropriate. This persistent problem will become increasingly urgent as the numbers of older persons continue upward and as the high cost of institutional care goes even higher. Some idea of the magnitude of the problem, even as it now exists, is provided by the HEW estimate that 100,000 of the 700,000 patients in acute care hospitals do not have to be there; but there they are, at an unnecessary cost of about $2.6 billion a year.

In studies and at hearings, the Senate Committee on Aging—particularly since the 1971 White House Conference on Aging—has challenged overdependence on such costly and inappropriate care. And yet, despite constant calls for "alternatives" and a "continuum of care," medicare and medicaid still pay only a tiny fraction of their reimbursements for home health care. There is new evidence that the so-called "deinstitutionalization" of patients from State hospitals is an uncertain and far-from-perfect process, often taking the form of "dumping" patients into unprepared communities. The opposite is also true: patients at such hospitals often stay on because there is no place else for them. For example, the committee heard in 1977 about a Florida hospital in which 300 "geriatric" patients continued to make their residence in the absence of any "community" which could accommodate them even though they were ready for discharge. This particular case is intensely ironic because the institution is the very same one in which Kenneth Donaldson fought for his release for 15 years before finally winning it through a Supreme Court decision.[5]

Another area of concern to this committee is the continuing inadequacy of Federal actions to control fraud and abuse in programs serving older Americans, particularly those programs related to health care. The committee, which in the past has given extensive attention to questionable practices in nursing homes and in "medicaid mills," dealt in 1977 with several problem situations which have arisen in conjunction with in-home services. We have attempted to sound an early alert to the need for accountability and quality of care in this area, and we will continue to do so. Enactment of the Medicare-Medicaid Reform Act of 1977 will help considerably; the work of this committee in winning passage of that legislation was acknowledged generously during congressional deliberations. But additional vigilance

[5] See testimony by Mr. Donaldson in "Mental Health and the Elderly," U.S. Senate Special Committee on Aging hearing, Sept. 29, 1975.

is essential. Working with other Senate and House units, the Senate Committee on Aging will do its part in assuring that close scrutiny continues.

A White House Conference Action Strategy

What is needed, as well, is a close and continuing inspection of the many adjustments in public policy which should take place as the graying of this Nation continues.

Debate during 1977 and 1978 on extension of the Older Americans Act has already yielded more widespread understanding of the service needs likely to arise as the older population continues its growth. But it would be unfortunate indeed if the issues thus examined were to be shunted aside after action on this legislation. A continuing and broadening debate on the Older Americans Act and its relationships to other service legislation should become just one major part of preparations for a White House Conference on Aging in 1981. Legislation for such a conference was introduced in 1977; within recent weeks, the administration has given its support. The way now seems clear for early approval.

As valuable as the 1971 conference was, the 1981 conference can accomplish far more if:

- Determined efforts are made to obtain essential data well in advance of the actual conference.
- Preparations for the conference are begun at the grassroots level at the earliest possible date.
- Wherever possible, pilot programs to demonstrate experimental approaches are in place for close examination before and during the conference.

The Committee on Aging will offer its help in all such efforts and will seek help from experts, organizations, and individual older persons. "Every Tenth American" is now every ninth American, and by 2015, it will be every eighth American and just 5 years later it will be every seventh American. How can we lose any time, including these precious few years before the 1981 White House Conference, in making ready for choosing the road toward opportunity, rather than drifting into the danger which will surely result from inaction or wrong action?

Frank Church,
Chairman.
Pete V. Domenici,
Ranking Minority Member.

CONTENTS

THE GRAYING OF EVERY TENTH AMERICAN OR EVERY NINTH AMERICAN[1]

Ever since 1966, when the older population (persons aged 65 plus) first exceeded 9½ percent of the resident population of the United States, this series of summaries of the characteristics and status of older persons has carried the rather catchy title, "Every Tenth American." The continuing more rapid growth of the older part of the population and the drop in the birth rate have brought the proportion of the older population to close to 11 percent, or one in nine; thus, "Every Ninth American."

This reflects a longtime trend. When we declared our independence in 1776, of the estimated 2.5 million inhabitants, about 50,000 were 65 plus. That was 2 percent or every 50th American.

By 1900, there were 3 million older Americans, comprising 4 percent of the total population or every 25th American. In mid-1977, 23.5 million older persons made up 10.9 percent of the 216.3 million resident in the United States, or every ninth American.

In 1977, the largest concentrations of older persons—12 percent or more of a State's population—occurred in 11 States: Florida (17.1 percent), Arkansas (13.3), Iowa and Missouri (13.0), Nebraska and South Dakota (12.8), Kansas and Rhode Island (12.6), Oklahoma (12.4), Pennsylvania (12.2), and Maine (12.0).

California and New York each had more than 2 million older people and Florida, Pennsylvania, Texas, Illinois, and Ohio each had more than 1 million.

Almost a quarter of the Nation's older people lived in just three States (California, New York, and Florida). Adding five more States (Pennsylvania, Texas, Illinois, Ohio, and Michigan) brings the eight-State total to almost half the older population of the United States. It takes 11 more States (New Jersey, Massachusetts, Missouri, Indiana, Wisconsin, North Carolina, Tennessee, Georgia, Minnesota, Virginia, and Alabama) or a total of 19 to account for just under three-quarters of the older population. It requires an additional 11 States, or a total of 30, to include 90 percent. The remaining 10 percent of the 65-plus population lived in the remaining 21 States (including the District of Columbia). (See exhibit A, page XXIV, for a detailed analysis of recent State trends.)

What is the older population like, and how does it change?

[1] Prepared by Herman B. Brotman, consultant to the Special Committee on Aging, U.S. Senate, and former assistant to the Commissioner on Aging, Department of Health, Education, and Welfare.

GROWTH IN NUMBERS

During the 70 years between 1900 and 1970 (the last census), the total population of the United States grew almost threefold while the older part grew almost sevenfold. The 65-plus population continues to grow faster than the under-65 portion; between 1960 and 1970, older Americans increased in number by 21 percent as compared with 13 percent for the under-65 population with a further 18 percent versus 5 percent in 1970–77.

The most rapid growth (the largest percentage increases) in 1960–70 occurred in Arizona (79 percent), Florida (78.2), Nevada (70.4), Hawaii (51.3), and New Mexico (37.7), all States with a large number of in-migrants. These five States also had the fastest growth rates in 1970–77. Florida still has the highest proportion of older people—17.1 percent in 1977 (14.5 in 1970). Alaska, with just over 2 percent, remains the State with smallest number and smallest proportion of older persons (9,000 or 2.2 percent in 1977).

TURNOVER

The older population is not a homogeneous group nor is it static. Every day, approximately 5,000 Americans celebrate their 65th birthday. Every day, approximately 3,600 persons aged 65 plus die. The *net* increase is about 1,400 a day, or a half million a year, but the 5,000 "newcomers" each day are quite different from and have lived through a quite different life history than those already 65-plus and are worlds apart from those already centenarians who were born shortly after the Civil War.

AGE

As of mid-1977, most older Americans were under 75 (62.2 percent); a half were under 73; and more than a third (36 percent) were under 70. Over 2 million Americans are 85 years of age or over. Accurate data on the number of centenarians is not available, but about 10,690 persons (end of 1976) are receiving cash social security benefits after producing some "proof of age" that shows ages of 100 or more. (See Projections, page XXIII, for changes in age distribution in the future.)

PERSONAL INCOME

Older economic units continue to have half the income of their younger counterparts. In 1976, half of the families headed by an older person had incomes of less than $8,721 as compared with $15,912 for families with under-65 heads; the median income of older persons living alone or with nonrelatives was $3,495 as compared with $7,030 for under-65 unrelated individuals.

Some 3.3 million or a seventh of the elderly had incomes below the official poverty thresholds ($3,417 for older couples and $2,720 for older individuals). This is a significant improvement over the 4.7 million or quarter of the elderly in 1970 and results primarily from the increases in social security benefits. Women and minority aged are heavily overrepresented among the aged poor. Many of the aged poor became poor after reaching these ages because of the half to two-thirds cut in income that results from retirement from the labor force.

The theoretic retired couple budget prepared by the Bureau of Labor Statistics for a modest but adequate intermediate standard of living came to $6,738 in autumn 1976. A lower budget came to $4,695; a higher came to $10,048.

INCOME SOURCES AND FINANCIAL STATUS

The Bureau of Labor Statistics' Consumer Expenditure Survey for 1972 and 1973 also collected data on income, taxes, and value of and net change in assets. For the purpose of the survey, "family" includes both a group of persons related by blood or marriage living in a single household and unrelated individuals living alone or with nonrelatives (see exhibit B, page XXIX, for more detailed data and for information on the characteristics of the "families").

A summary of the highlights shows the following by age of family head:

Category	Average annual		
		65-plus	
	Under 65	Amount	Index: Under 65 equals 100
Money income before taxes	$12,702	$6,292	50
Wages and salaries	10,294	1,524	15
Self-employment	994	402	40
Social security and railroad retirement	201	2,085	1,040
Government retirement, veterans, unemployment	253	450	178
Income from assets, investments, etc	383	1,134	296
Other, including welfare, contributions, pensions, etc	577	697	121
Personal taxes	1,978	528	27
Income after taxes	10,728	5,764	54
Other money receipts	227	188	82
Goods and services received	149	68	46
Mortgage principal paid	−358	−76	21
Net increase in assets	942	353	38
Market value of financial assets	5,490	13,511	246

The older units had about half the income of the younger, primarily because the larger amounts from retirement benefits and income from investments for the older families did not balance out the loss of earnings from employment. As is to be expected, the financial assets of older families was greater than for the younger. Not as expected was the net increase in assets held by the elderly albeit at a lower figure than for the younger units; this is a result of the fact that older persons not only add less new assets but tend to avoid new liabilities completely.

EXPENDITURES

Older Americans spend proportionately more of their income on gifts and contributions, food, housing, and health and personal care and less on other items in a pattern generally similar to that of other low-income groups. Persons living on fixed incomes are hit hard by price inflation and the elderly command little potential for personal improvement of income. Even formulas that adjust retirement payments for changes in price indices are of only partial assistance since, at best, they provide only for a restoration of the previous living standard, they provide the "catch-up" well after the fact, and older people have little in easily available savings to carry them over.

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The BLS survey (see exhibit B) shows the following by age of family head:

Category	Average annual			Distribution		
		65-plus			65-plus	
	Under 65	Amount	Index [1]	Under 65	Percent	Index [1]
Total	$10,059	$5,400	54	100.0	100.0	100
Insurance and pension	874	176	20	8.7	3.3	38
Gifts and contributions	410	490	120	4.1	9.1	222
Other consumption	8,775	4,734	54	87.2	87.7	101
Food	1,831	1,155	63	18.2	21.4	118
Alcoholic beverages	86	30	35	.9	.6	67
Tobacco products	146	60	41	1.4	1.1	79
Housing	2,619	1,559	60	26.0	28.9	111
House furnishings and equipment	438	174	40	4.4	3.2	73
Clothing	737	290	39	7.3	5.4	74
Transportation (excluding trips)	1,801	689	38	17.9	12.8	72
Health care (out of pocket)	480	448	94	4.8	8.3	173
Personal care	105	82	78	1.0	1.5	150
Recreation	712	336	47	7.1	6.2	87

[1] Index: Under 65 equals 100.

INCOME MAINTENANCE

Old Age, Survivors, and Disability Insurance

In September 1977, the Social Security Administration paid cash benefits to 33.7 million persons of all ages for a total of $7,051 million. Subtracting the 4.8 million under-65 disabled workers and their dependents (paid benefits from the disability insurance trust fund), there remains 28.9 million persons and $6,162 million in payments.

For retired workers and their dependents, the average monthly payment to the retired worker was $241.24; to their wives and husbands, $122.25; and to their children, $93.35. Almost 59 percent of all retired workers are receiving "reduced benefits," having started to draw benefits before attaining age 65.

For survivors of deceased workers, the average monthly payment to widowed mothers or fathers with children was $171.92; to the children, $164.39; to the older widows and widowers, $223.66; to disabled widows and widowers, $156.40; and to parents, $197.91.

Special age-72 beneficiaries received $78.21 and $39.29 for a wife.

Of the total 33.7 million beneficiaries in September 1977, 21.7 million or about 65 percent were aged 65 plus, as follows: 15.8 million retired workers, 5.8 million survivors and dependents, and 166,000 special age-72 beneficiaries.

Supplementary Security Income

In September 1977, the Social Security Administration sent checks to 2,075,000 65-plus persons eligible because of age and need, totalling $203.1 million. Of this amount, $147.5 million was Federal payments to persons in all States and $55.6 million was State supplements administered by the Federal agency for the 27 States that have made such an arrangement. One State pays no State supplement and 23 pay supplements (totaling $15 million) directly to their own eligible aged residents under the State law.

In addition, it is estimated, about 23,000 65-plus persons received SSI payments as "blind" and 260,000 as "disabled" beneficiaries with higher payments.

HEALTH

Total Health Costs

The total health bill in the United States rose from $38.9 billion in 1965, when it amounted to 5.9 percent of the gross national product, to $139.3 billion in 1976, 8.6 percent of the GNP. This more than tripling of the costs of health care results from vast technical changes, very rapid price increases, the "aging" of the population, and the increased utilization made possible by the provision of increased resources, especially through public programs.

In this period, hospital care costs rose most rapidly, proportionately from 34 percent of total costs to 40 percent; nursing home costs rose from 3 percent to 8 percent of the total; the other components increased in amounts but decreased proportionately.

Personal Health Care Expenditures

These expenditures (which exclude costs of research, construction, and certain public health activities like contagious disease control) rose from $33.5 billion in 1965 to $120.4 billion in 1976.

Per capita health care costs in 1976 for an older American came to $1,521, 3.5 times the $438 spent for each under-65 person. $689 or 45 percent of the $1,521 went for hospital care, $351 or 23 percent for nursing home care, $256 or 17 percent for physician services, $121 or 8 percent for drugs, $32 or 2 percent for dentists' services, and the remaining $55 for all other items. Older people represent almost 11 percent of the total population but account for 29 percent of total personal health care expenditures ($34.9 billion out of $120.4 billion). Of the total per capita cost for older people, almost 68 percent was paid by public programs of all types ($1,030 out of $1,521); medicare alone covered 43 percent.

Comparison of levels and sources of payments on a per capita basis over the last 10 years shows the following:

Age and year	Total	Direct out of pocket	3d-party payments			
			Total	Govern-ment	Private health in-surance	Philan-thropy and industry
Amount:						
Under 65:						
1966	$155	$79	$76	$30	$42	$3
1976	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
65-plus:						
1966	445	237	209	133	71	5
1976	1,521	404	1,118	1,030	81	6
Distribution (percent):						
Under 65:						
1966	100.0	51.1	48.9	19.4	27.3	2.2
1976	100.0	34.9	65.1	29.0	34.5	1.7
65-plus:						
1966	100.0	53.2	46.8	29.8	15.9	1.1
1976	100.0	26.5	73.5	67.7	5.4	.4

It should be noted that the above comparison shows a significant increase in the utilization of health care in addition to a doubling of health care prices, with a pronounced shift toward third-party payments, especially public programs.

Health Status

In a 1975 household interview survey of a sample of the noninstitutional population, over two-thirds (69 percent) of the older persons reported their health as good or excellent as compared with others of their own age. Almost 22 percent reported their health as fair and 9 percent as poor. Minority group members, residents of the South, residents of nonmetropolitan areas, and persons with low incomes were more likely to report themselves in poor health.

Counting older people in institutions as, by definition, in poor health, a total of 14 percent of all older people consider themselves in poor health.

The most frequently reported chronic conditions are: Arthritis (38 percent), hearing impairments (29 percent), and vision impairments, hypertension, and heart conditions (each about 20 percent).

While over 80 percent of the noninstitutional older population reported some chronic condition, less than 18 percent said that it limited their mobility. Some 5 percent were confined to the house (but only slightly over 1 percent were bedridden); almost 7 percent needed help in getting around (less than 2 percent needed the help of another person and less than 5 percent needed an aid like a cane, walker, or wheelchair); and almost 6 percent could move around alone, but with some difficulty.

Utilization

Older people are subject to more disability, see physicians 50 percent more often, and have about twice as many hospital stays that last almost twice as long as is true for younger persons. Still, some 82 percent reported no hospitalization in the previous year.

Based on data for 1974, on the average, a person aged 55–64 spends 2 days per year in a short-stay hospital. This increases to an average of 3.3 days for persons aged 65–74 and to 5.6 days for those 75 plus.

The same study shows that, on the average, a person aged 55–64 spends a fraction of a day per year in a nursing home, with a jump to 4.4 days for persons aged 65–74, 21.5 days for those aged 75–84, and 86.4 days for those 85 plus.

Of the 961,500 older people in nursing homes at the time of a 1973–74 study, 17 percent were aged 65–74, 40 percent were 75–84, and 43 percent were 85 plus; in the total older population, the comparable percentages were 62, 30, and 8. In the nursing home population, 72 percent were women (60 in the total), 69 percent were widowed, 15 percent were single, and 12 percent married; 95 percent were white. Of every 100 admissions to these nursing homes, almost 40 came from their own private residences (only 13 had been living alone), 36 came from general hospitals, 14 from other nursing homes or related facilities, and the rest came primarily from mental institutions and boarding homes.

Death Rates

In the 10-year period between 1965 and 1975, annual death rates for older persons dropped about 11 percent from 6.1 per 100 to 5.4 per 100. Within the older population, there were these variations: The rate for persons 65–74 dropped 16 percent from 3.8 to 3.2 per 100; the rate for those 75–84 declined only 10 percent from 8.2 to 7.4 per 100; while the rate for the 85-plus dropped 25 percent from 20.2 to 15.2.

The rate for deaths of older persons from heart disease dropped 15 percent, from 2.8 to 2.4 per 100 per year and the rate for deaths from stroke dropped 19 percent, from 0.9 to 0.7 per 100. On the other hand, the rate for deaths from cancer increased 7 percent, from 0.9 to 1.0. Still, these three causes of death accounted for three-quarters of the deaths of older people in both 1965 and 1975.

LIFE EXPECTANCY

Based on death rates in 1975, average life expectancy at birth was 72.5, 68.7 years for males but almost 8 years longer or 76.5 for females. At age 65, average remaining years of life were 16.0, 13.7 for men but more than 4 years longer or 18.0 for women. The 25-year increase in life expectancy at birth since 1900 results from the wiping out of most of the killers of infants and of the young—much smaller improvement has occurred in the upper ages when chronic conditions and diseases become the major killers. Many more people now reach age 65 (about 75 percent versus 40 percent in 1900) but, once there, they live only 4.1 years longer than did their ancestors who reached that age in the past. Should recent decreases in death rates continue among older persons, especially from cardiovascular conditions, life expectancy in the later years may increase further.

SEX RATIOS

As a result of the yet unexplained longer life expectancy for females, most older persons are women—13.9 million as compared with 9.6 million men in mid-1977. Between ages 65 and 74, there are 130 women per 100 men; after 74, there are 176. In the 85-plus group, there are 217 women for every 100 men. The average for the total 65-plus population is 146 women per 100 men. (See also, "Projections," below.)

MARITAL STATUS

In 1977, most older men were married (7 million or 77 percent) but most older women were widows (6.8 million or 52 percent). There are 5.2 times as many older widows as widowers. Among 75-plus women, almost 70 percent were widows. Almost 40 percent of the married 65-plus men have under-65 wives. In 1975, among the 2.2 million marriages of persons of all ages, there were about 21,300 brides and 40,100 grooms aged 65-plus. For about 1,200 of these older brides and 1,800 older grooms, it was a first marriage. For the remainder, it was a remarriage, mostly after widowhood rather than divorce. Marriage rates for older men are seven times those for older women for marriages in 1975; for first marriages, the rates for older men are 2.5 times those for older women; for remarriages, the rate for men is 8.6 times that for women.

EDUCATIONAL ATTAINMENT

In 1977, almost half (47 percent) of the older Americans had not completed one year of high school; the median for the 25–64 age group was high school graduation. About 2.2 million or 9 percent of the older people were "functionally illiterate," having had no schooling or less than 5 years. At the other end of the scale, about 8 percent were college graduates.

LIVING ARRANGEMENTS

In 1977, more than 8 of every 10 older men, but only 6 of every 10 older women, lived in family settings; the others lived alone or with nonrelatives except for the 1 in 20 who lived in an institution (1 in 5 in the 85-plus age group). About three-quarters of the older men lived in families that included the wife but only one-third of the older women lived in families that included the husband. More than a third of all older women lived alone. More than three times as many older women lived alone or with nonrelatives than did older men.

PLACE OF RESIDENCE

In 1977, a slightly smaller proportion of older than of younger persons lived in metropolitan areas (63 versus 68 percent). Within the metropolitan areas, however, about half of the older people lived in the central city but almost 60 percent of the under-65 lived in the suburbs. The inevitable aging of the residents of the suburbs which began their rapid expansion in the post-World War II period will soon bring a reversal of proportions and the development of the same problems, lacks, and barriers faced by the inner city aged.

VOTER PARTICIPATION

In the 1976 Presidential election, older people made up 15 percent of the voting age population but cast 16 percent of the votes. Some 62 percent of the older population voted, a much higher proportion than the under-35 group but somewhat lower than the 35–64 groups. A higher *proportion* of older men than of women voted, but the women still outnumbered the men voters. Voter participation falls off sharply after age 75.

MOBILITY

In the March 1977 household survey, 9.6 percent or 2.1 million of the persons then aged 65-plus reported that they had moved from one residence to another in the 2-year period since March 1975. In a pattern that has remained consistent for a long period of time, remembering that most moves are made for occupational reasons, some 6 percent of the elderly moved within the same county, 2 percent moved to a different county within the same State, and only 1.7 percent moved across a State line. The impression that there is more extensive interstate migration of older people arises from the very visible flow but only toward a very few States—Florida, Arizona, and Nevada.

EMPLOYMENT

In 1977, just over 20 percent of 65-plus men (1.8 million) and 8 percent of 65-plus women (1.1 million) were in the labor force with concentrations in three low-earnings categories: Part time, agriculture, and self-employment. Unemployment ratios were low due partly to the fact that in a period of sizable unemployment discouraged older workers stop seeking jobs and are not counted as being in the labor force at all. For those remaining actively in the labor force and counted as unemployed, the average duration of unemployment was longer than for younger workers.

AUTOMOBILE OWNERSHIP

As is true for most major household appliances, ownership of automobiles by older households is considerably below that of households with younger heads but at least part of the difference depends on income level rather than age, health, or choice. A 1974 Census Bureau survey shows that 62 percent of older households owned at least one car as compared with 86 percent of younger households. However, there is a strong relationship between automobile ownership and income level at all ages and a much higher proportion of low-income households among the elderly—thus accounting, in part, for the lower ownership in older households.

PROJECTIONS

The "safest" Census Bureau population projections of the size and composition through 2050 are the so-called "series II" which are based on an ultimate cohort fertility rate of 2.1 (an ultimate level of 2.1 children per woman or eventual zero population growth), small improvements in life expectancy including that for older persons, narrowing of the gap between white and black rates, constant 400,000 net immigration, and no new major medical "cures" of chronic diseases.

POPULATION PROJECTIONS (SERIES II), TOTAL AND 65 PLUS BY SEX, 1977–2050

[Numbers in thousands]

Year	All ages	65-plus				
		Both sexes			Female	
		Number	Percent of all ages	Male	Number	Per 100 men
1977	216,745	23,431	10.8	9,545	13,885	145
1980	222,159	24,927	11.2	10,108	14,819	147
1985	232,880	27,305	11.7	11,012	16,293	148
1990	243,513	29,824	12.3	11,999	17,824	149
1995	252,750	31,401	12.4	12,602	18,799	149
2000	260,378	31,822	12.2	12,717	19,105	150
2005	267,603	32,436	12.1	12,924	19,512	151
2010	275,335	34,837	12.7	13,978	20,858	149
2015	283,164	39,519	14.0	16,063	23,456	146
2020	290,115	45,102	15.6	18,468	26,634	144
2025	295,742	50,920	17.2	20,861	30,059	144
2030	300,349	55,024	18.3	22,399	32,624	146
2035	304,486	55,805	18.3	22,434	33,371	149
2040	308,400	54,925	17.8	21,816	33,108	152
2045	312,054	54,009	17.3	21.335	32.674	153
2050	315,622	55,494	17.6	22,055	33,439	152

If the present fertility rate of approximately 1.8 should continue at this low level rather than the 2.1 rate assumed above, the size of the total population would be smaller and the *proportion* of older people would be larger. The increasing number and proportion of older persons reflects both the impact of longer life expectancy and the movement of the post-World War II baby boom through the population pyramid. Projections based on lower fertility rates also show a much slower rate of growth of the older population after 2030 when today's babies and youngsters start reaching age 65.

The above projections represent averages. Important differences by sex and age group within the 65-plus are shown as follows:

POPULATION PROJECTIONS, TRENDS WITHIN THE 65-PLUS AGE GROUP, 1977–2050

[Percent change]

Sex	1977–2000	2000–25	2025–50
Both sexes, 65 plus	+35.8	+60.0	+9.0
65 to 74	+19.6	+77.5	−6.7
75 to 84	+56.0	+41.1	+14.0
85 plus	+84.1	+32.4	+91.6
Male, 65 plus	+33.2	+64.0	+5.7
65 to 74	+21.3	+79.1	−6.3
75 to 84	+54.7	+44.1	+13.5
85 plus	+64.4	+29.9	+92.9
Female, 65 plus	+37.6	+57.3	+11.2
65 to 74	+18.3	+76.2	−7.1
75 to 84	+56.8	+39.4	+14.3
85 plus	+93.2	+33.4	+91.1

Thus, comparison of the 25-year time spans shows continuing increase to 2000, very rapid growth from 2000 to 2025 as the post-war babies reach their later years, and a sharp deceleration as the current low birth rates are reflected in older people. Significantly, the traditionally more rapid growth of the older women is reversed in the 2000 to 2025 period. But of even greater significance is the fact that between now and 2000 the oldest part of the older population will grow most rapidly, then be reversed between 2000 and 2025, and return to the current trend after 2025.

Does the age shift in the population create insurmountable "burdens"? Computation of a gross dependency ratio based on the assumption that the young and the old are dependent on the middle group, the so-called productive-age population, tends to show a reasonable "burden" on the middle group under reasonable economic and labor force assumptions, as follows:

Year	Number aged under 18 per 100 aged 18 to 64	Number aged 65-plus per 100 aged 18 to 64	Total
1970	61.1	17.6	78.7
1977	49.7	18.2	67.9
2000	43.2	20.0	63.2
2025	42.1	29.6	71.7
2050	41.7	30.2	71.9

Exhibit A

Recent State Trends in the Older Population, 1970–77

Between 1970 and 1977, the Nation's older population (65-plus) increased from 20 million to 23.5 million at a rate much faster than was true for the under-65 population (18 percent versus 5 percent). This was an acceleration of the similar trend between 1960 and 1970 when the increases were 21 and 13 percent.

These national trends, however, represent the averaging out of a variety of separate State trends. Details are presented in the analysis and tables that follow.

PROPORTION OF POPULATION AGED 65 PLUS

For the Nation as a whole (the 50 States and the District of Columbia), the proportion of the total population in the 65-plus group rose from 9.8 percent in 1970 to 10.9 percent in 1977. In two States, the proportion fell as the under-65 population grew faster than the older population (Wyoming, from 9.1 to 8.6 percent, and Alaska, from 2.3 to 2.2 percent). In the remaining States, the proportion increased from only 0.1 percentage points (Colorado, from 8.5 to 8.6 percent) to 2.6 percentage points (Florida, from 14.5 to 17.1 percent).

SUMMARY: PERCENT OF STATE'S POPULATION AGED 65 PLUS, 1977

Under 7.9 (3)—Alaska, Hawaii, Utah.
7.9–8.8 (7)—Colorado, Maryland, Nevada, New Mexico, South Carolina, Virginia, Wyoming.
8.9–9.8 (6)—Delaware, Georgia, Idaho, Louisiana, Michigan, Texas.
9.9–10.8 (10)—Alabama, California, District of Columbia, Illinois, Indiana, Montana, North Carolina, Ohio, Tennessee, Washington.
10.9 (2)—Arizona, Connecticut (U.S. average).
11.0–11.9 (12)—Kentucky, Massachusetts, Minnesota, Mississippi, New Hampshire, New Jersey, New York, North Dakota, Oregon, Vermont, West Virginia, Wisconsin.
12.0–12.9 (7)—Kansas, Maine, Nebraska, Oklahoma, Pennsylvania, Rhode Island, South Dakota.
13.0–13.9 (3)—Arkansas, Iowa, Missouri.
Over 14.0 (1)—Florida.

Variations in the relative rates of increase changed the rankings of the States between 1970 and 1977. While six States maintained the same rank number in 1977 as in 1970 (Alaska, Florida, Hawaii, Kansas, South Dakota, and Vermont), 25 States rose in rank from 1 to a maximum of 10 ranks (Arizona) and 20 States dropped in rank from 1 to a maximum of 10 ranks (Wyoming).

DISTRIBUTION AMONG THE STATES

The older population tends to be distributed among the States in the same general pattern as the total population except that there is a slightly greater concentration of older persons in some of the larger States. In the accompanying table by State rank order, at the points where the States in the total population column and the

65-plus population column match exactly, the percentages are as follows:

States	All ages		65-plus	
	Percent of United States	Cumulative	Percent of United States	Cumulative
California	10.1	10.1	9.3	9.3
New York	8.3	18.4	8.9	18.2
Texas, Pennsylvania, Illinois, Ohio, Michigan, Florida	29.5	47.9	30.9	49.1
New Jersey	3.4	51.3	3.4	52.5
Massachusetts	2.7	54.0	2.9	55.4
North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee, Maryland, Minnesota, Louisiana, Alabama, Washington, Kentucky, Connecticut, Iowa, South Carolina, Oklahoma, Colorado, Mississippi, Oregon, Kansas, Arizona, and Arkansas	38.6	92.6	37.7	93.1
West Virginia	.9	93.5	.9	94.0
Nebraska	.7	94.2	.9	94.9
Utah, New Mexico, Maine, Rhode Island	2.1	96.3	1.9	96.8
Hawaii, Idaho, New Hampshire, Montana, District of Columbia, South Dakota, North Dakota	2.5	98.8	2.4	99.2
Nevada, Delaware, Vermont	.8	99.6	.6	99.8
Alaska, Wyoming	.4	100.0	.2	100.0

California and New York, each with more than 2 million older people, accounted for almost 4.3 million or 1 in 5 of the older people of the United States in 1977. Six additional States (Florida, Pennsylvania, Texas, Illinois, Ohio, and Michigan), with almost 7.3 million older people, brought the eight-State total to 11.5 million or almost half of the Nation's elderly.

Stated another way, almost a quarter of the Nation's older people lived in just three States (California, New York, and Florida). Adding five more States (Pennsylvania, Texas, Illinois, Ohio, and Michigan) brings the eight-State total to almost half of the older population of the United States. It takes 11 more States (New Jersey, Massachusetts, Missouri, Indiana, Wisconsin, North Carolina, Tennessee, Georgia, Minnesota, Virginia, and Alabama) or a total of 19 to account for just under three-quarters of the older population. It requires an additional 11 States, or a total of 30, to include 90 percent. The remaining 10 percent of the 65-plus population lived in the remaining 21 States (including the District of Columbia).

RESIDENT POPULATION AGED 65-PLUS, BY STATE, 1970 AND 1977

State	Number (thousands)		Percent increase		Percent of all ages		State rank [2]					
							Number		Percent increase		Percent of all ages	
	1970 [1]	1977	1960–70	1970–77	1970	1977	1970	1977	1960–70	1970–77	1970	1977
Total, 51 "States"	19,972	23,494	21.1	17.6	9.8	10.9						
Alabama	324	398	24.7	22.8	9.4	10.8	21	19	16	14	[3] 30	[3] 26
Alaska	7	9	27.9	28.6	2.3	2.2	51	51	11	[3] 7	51	51
Arizona	161	250	79.0	55.3	9.1	10.9	35	31	1	2	[3] 34	[3] 24
Arkansas	237	285	22.0	20.3	12.3	13.3	28	28	21	22	[3] 3	2
California	1,792	2,185	30.9	21.9	9.0	10.0	2	1	9	15	36	34
Colorado	187	224	18.8	19.8	8.5	8.6	33	33	24	23	38	44
Connecticut	288	340	19.1	18.1	9.5	10.9	26	26	23	26	[3] 27	[3] 24
Delaware	44	53	22.6	20.5	8.0	9.1	48	48	20	[3] 19	[3] 42	40
District of Columbia	70	71	2.4	1.4	9.3	10.3	41	45	51	51	[3] 32	33
Florida	985	1,444	78.2	46.6	14.5	17.1	7	3	2	3	1	1
Georgia	365	456	26.4	24.9	8.0	9.0	17	16	15	12	[3] 42	41
Hawaii	44	63	51.3	43.2	5.7	7.0	47	46	4	4	50	50
Idaho	67	84	16.3	25.4	9.5	9.8	44	42	29	11	[3] 27	35
Illinois	1,089	1,194	12.2	9.6	9.8	10.6	4	6	40	46	24	[3] 28
Indiana	492	554	10.8	12.6	9.5	10.4	12	12	[3] 45	40	[3] 27	[3] 30
Iowa	349	374	6.9	7.2	12.4	13.0	19	22	49	49	2	[3] 3
Kansas	265	293	10.8	10.6	11.8	12.6	27	27	[3] 45	44	7	[3] 7
Kentucky	336	382	15.1	13.7	10.4	11.1	20	21	35	34	21	[3] 20
Louisiana	305	363	27.0	19.0	8.4	9.3	23	23	12	25	[3] 39	[3] 38
Maine	114	130	7.6	14.0	11.5	12.0	36	36	48	33	9	11
Maryland	298	359	32.3	20.5	7.6	8.7	25	24	8	[3] 19	45	43
Massachusetts	633	687	11.3	8.5	11.1	11.9	10	10	43	48	[3] 10	12
Michigan	749	850	18.0	13.5	8.4	9.3	8	8	25	[3] 35	[3] 39	[3] 38
Minnesota	408	454	15.4	11.3	10.7	11.4	15	[3] 17	[3] 33	43	[3] 14	18
Mississippi	221	266	17.0	20.4	10.0	11.1	30	30	27	21	22	[3] 20
Missouri	558	622	11.4	11.5	11.9	13.0	11	11	42	42	6	[3] 3
Montana	69	79	5.1	14.5	9.9	10.4	43	43	50	32	23	[3] 30
Nebraska	183	199	11.8	8.7	12.3	12.8	34	35	41	47	[3] 3	[3] 5
Nevada	31	51	70.4	64.5	6.3	8.1	49	49	3	1	49	48
New Hampshire	78	93	15.8	19.2	10.6	11.0	39	40	[3] 31	24	[3] 19	[3] 22

See footnotes at end of table.

RESIDENT POPULATION AGED 65-PLUS, BY STATE, 1970 AND 1977—Continued

State	Number (thousands)		Percent increase		Percent of all ages		State rank [2]					
							Number		Percent increase		Percent of all ages	
	1970[1]	1977	1960–70	1970–77	1970	1977	1970	1977	1960–70	1970–77	1970	1977
New Jersey	694	808	24.4	16.4	9.7	11.0	9	9	17	30	[3]25	[3]22
New Mexico	70	98	37.7	40.0	6.9	8.2	42	[3]38	5	5	48	47
New York	1,951	2,082	15.8	6.7	10.7	11.6	1	2	[3]31	50	[3]14	17
North Carolina	412	530	32.7	28.6	8.1	9.6	14	14	7	[3]7	41	[3]36
North Dakota	66	77	13.3	16.7	10.7	11.8	45	44	36	[3]27	[3]14	[3]15
Ohio	993	1,110	11.2	11.8	9.3	10.4	5	7	44	41	[3]32	[3]30
Oklahoma	299	349	20.1	16.7	11.7	12.4	24	25	22	[3]27	8	9
Oregon	226	274	23.5	21.2	10.8	11.5	29	29	19	17	13	[3]16
Pennsylvania	1,267	1,432	12.7	13.0	10.7	12.2	3	4	37	38	[3]14	10
Rhode Island	104	118	16.1	13.5	10.9	12.6	37	37	30	[3]35	12	[3]3
South Carolina	190	247	26.8	30.0	7.3	8.6	32	32	13	6	[3]46	[3]44
South Dakota	80	88	12.5	10.0	12.1	12.8	38	41	[3]38	45	5	[3]5
Tennessee	382	465	24.0	21.7	9.7	10.8	15	15	18	16	[3]25	[3]26
Texas	988	1,228	32.9	24.3	8.8	9.6	6	5	6	13	37	[3]36
Utah	77	98	29.4	27.3	7.3	7.7	40	[3]38	10	10	[3]46	49
Vermont	47	54	8.6	14.9	10.6	11.2	46	47	47	31	[3]19	19
Virginia	354	454	26.6	28.3	7.8	8.8	18	[3]17	14	9	44	42
Washington	320	386	15.4	20.6	9.4	10.6	22	20	[3]33	18	[3]30	[3]28
West Virginia	194	219	12.5	12.9	11.1	11.8	31	34	[3]38	39	[3]10	[3]13
Wisconsin	471	534	17.4	13.4	10.7	11.5	13	13	26	37	[3]14	[3]16
Wyoming	30	35	16.6	16.7	9.1	8.6	50	50	28	[3]27	[3]34	[3]44

[1] Corrected for errors in numbers of centenarians.
[2] States ranked in decreasing order; State with largest quantity is ranked 1.
[3] Tied in ranking. States with identical quantities receive identical rank numbers with following rank number(s) skipped to allow for the number in the tie; e.g., 3 States tied for 5th place will each be shown as "[3]5" but next State will be ranked "8" to compensate for skipping of 6th and 7th rank.

Source of data: Bureau of the Census (published and unpublished). Estimates and computations supplied.

RESIDENT POPULATION, TOTAL AND AGED 65-PLUS, STATES IN RANK NUMBER ORDER, 1977

Rank	Total, all ages: State	Number (thousands)	Percent: Distribution	Percent: Cumulative	65-plus: State	Number (thousands)	Percent: Distribution	Percent: Cumulative	Rank
1	California	21,896	10.1	10.1	California	2,185	9.3	9.3	1
2	New York	17,924	8.3	18.4	New York	2,082	8.9	18.2	2
3	Texas	12,830	5.8	24.2	Florida	1,444	6.2	24.4	3
4	Pennsylvania	11,785	5.4	29.6	Pennsylvania	1,432	6.1	30.5	4
5	Illinois	11,245	5.2	34.8	Texas	1,228	5.2	35.7	5
6	Ohio	10,701	5.0	39.8	Illinois	1,194	5.1	40.8	6
7	Michigan	9,129	4.2	44.0	Ohio	1,110	4.7	45.5	7
8	Florida	8,452	3.9	47.9	Michigan	850	3.6	49.1	8
9	New Jersey	7,329	3.4	51.3	New Jersey	808	3.4	52.5	9
10	Massachusetts	5,782	2.7	54.0	Massachusetts	687	2.9	55.4	10
11	North Carolina	5,525	2.6	56.6	Missouri	622	2.6	58.0	11
12	Indiana	5,330	2.5	59.1	Indiana	554	2.4	60.4	12
13	Virginia	5,135	2.4	61.5	Wisconsin	534	2.3	62.7	13
14	Georgia	5,048	2.3	63.8	North Carolina	530	2.3	65.0	14
15	Missouri	4,801	2.2	66.0	Tennessee	465	2.0	67.0	15
16	Wisconsin	4,651	2.2	68.2	Georgia	456	1.9	68.9	16
17	Tennessee	4,299	2.0	70.2	Minnesota	454	1.9	70.8	17
18	Maryland	4,139	1.9	72.1	Virginia	454	1.9	72.7	18
19	Minnesota	3,975	1.8	73.9	Alabama	398	1.7	74.4	19
20	Louisiana	3,921	1.8	75.7	Washington	386	1.6	76.0	20
21	Alabama	3,690	1.7	77.4	Kentucky	382	1.6	77.6	21
22	Washington	3,658	1.7	79.1	Iowa	374	1.6	79.2	22
23	Kentucky	3,458	1.6	80.7	Louisiana	363	1.5	80.7	23
24	Connecticut	3,108	1.4	82.1	Maryland	359	1.5	82.2	24
25	Iowa	2,879	1.3	83.4	Oklahoma	349	1.5	83.7	25
26	South Carolina	2,876	1.3	84.7	Connecticut	340	1.4	85.1	26
27	Oklahoma	2,811	1.3	86.0	Kansas	293	1.3	86.4	27
28	Colorado	2,619	1.2	87.2	Arkansas	285	1.2	87.6	28
29	Mississippi	2,389	1.1	88.3	Oregon	274	1.2	88.8	29
30	Oregon	2,376	1.1	89.4	Mississippi	266	1.1	89.9	30
31	Kansas	2,326	1.1	90.5	Arizona	250	1.1	91.0	31
32	Arizona	2,296	1.1	91.6	South Carolina	247	1.1	92.1	32
33	Arkansas	2,144	1.0	92.6	Colorado	224	1.0	93.1	33
34	West Virginia	1,859	.9	93.5	West Virginia	219	.9	94.0	34
35	Nebraska	1,561	.7	94.2	Nebraska	199	.9	94.9	35
36	Utah	1,268	.6	94.8	Maine	130	.6	95.5	36
37	New Mexico	1,190	.6	95.4	Rhode Island	118	.5	96.0	37
38	Maine	1,085	.5	95.9	New Mexico	98	.4	96.4	38
39	Rhode Island	935	.4	96.3	Utah	98	.4	96.8	39
40	Hawaii	895	.4	96.7	New Hampshire	93	.4	97.2	40
41	Idaho	857	.4	97.1	South Dakota	88	.4	97.6	41
42	New Hampshire	849	.4	97.5	Idaho	84	.4	98.0	42
43	Montana	761	.4	97.9	Montana	79	.3	98.3	43
44	District of Columbia	690	.3	98.2	North Dakota	77	.3	98.6	44
45	South Dakota	689	.3	98.5	District of Columbia	71	.3	98.9	45
46	North Dakota	653	.3	98.8	Hawaii	63	.3	99.2	46
47	Nevada	633	.3	99.1	Vermont	54	.2	99.4	47
48	Delaware	592	.3	99.4	Delaware	52	.2	99.6	48
49	Vermont	483	.2	99.6	Nevada	51	.2	99.8	49
50	Alaska	407	.2	99.8	Wyoming	35	.2	100.0	50
51	Wyoming	406	.2	100.0	Alaska	9	----	100.0	51

Source of data: Bureau of the Census (published and unpublished). Computations supplied.

Exhibit B

Income and Expenditures, 1972–73

Approximately every 10 years, the Bureau of Labor Statistics collects detailed data on income and expenditures from a national

sample of economic units (families and unrelated individuals) based in part on "diaries" and in part on household interviews. While the original purpose is to examine the validity of the consumption patterns and weights used in the Consumer Price Index computations, the surveys provide extremely significant data on a national basis of the sources and amounts of income, the holdings and returns on financial assets, and expenditures for consumption and other purposes. Further, the data may be cross-classified by the characteristics of the units in the sample.

The following, analytical tables show the data (annual averages for 1972–73) classified by the age of the family head (all ages, under 65, and 65-plus) with the term "family" applied to both kinds of economic units, the members of a traditional family living in a household and an unrelated individual living alone or with nonrelatives. Part A shows the characteristics of these "families." Parts B and C show the detailed data on income and expenditures summarized in the earlier text but also shows the proportion of "families" reporting such an income or expenditure item.

Most of the data are from published sources but the computation of the under-65 columns, the distributions, and the indices (the "percent of under 65" column is an index based on "under-65=100" were supplied by the author.

FAMILY INCOME AND EXPENDITURES, BY AGE OF HEAD CONSUMER EXPENDITURE INTERVIEW SURVEY, 1972–73

A. FAMILY CHARACTERISTICS

Item	All ages	Under 65	65-plus	
			Annual average	Percent of under 65
Number of families (thousands)	71,220	56,970	14,250	25
1-person families	16,761	10,218	6,543	64
Percent of total families	24	18	46	256
FAMILY CHARACTERISTICS				
Average:				
Size	2.9	3.2	1.7	53
Income before taxes	$11,419	$12,701	$6,292	50
Income after taxes	$9,731	$10,728	$5,764	54
Age of head	48	42	73	174
Children under 18	1.0	1.2	0.1	8
Persons 65 plus	0.3	(1)	1.3	(2)
Automobiles owned	1.3	1.4	0.8	57
Percent distribution by:				
Housing tenure:				
Owners	59	57	66	116
Renters	37	38	32	84
Not reported	4	5	2	40
Race of head:				
White	89	89	91	102
Black	10	10	8	80
Other	1	1	1	100
Education of head:				
1 to 9 years of schooling	21	15	46	307
9 to 12 years	43	46	30	65
12 plus years	29	32	16	50
None or not reported	6	6	8	133
Automobile ownership: Own 1 plus	80	86	58	67

[1] Less than half the smallest quantity that can be shown.
[2] Not applicable.

B. INCOME, BY SCURCE, TAXES, ASSETS, AND LIABILITIES

Item	Percent reporting			Average annual amount			
						65-plus	
	All ages	Under 65	65-plus	All ages	Under 65	Amount	Percent of under 65
Money income before taxes	98.1	98.1	98.0	$11,419.16	$12,701.73	$6,291.60	50
Wages and salaries, total	78.1	89.7	31.6	8,539.60	10,294.41	1,524.05	15
Money, wages and salaries, civilians	74.8	89.7	27.3	8,475.92	10,214.25	1,526.24	15
Union dues paid	17.2	20.0	3.0	−17.53	−21.29	−2.50	12
Other occupational expenses paid	21.2	24.8	6.9	−33.57	−38.86	−12.43	32
Rent received as pay	.9	1.0	.4	9.78	10.95	5.12	47
Meals received as pay	8.6	9.9	3.5	18.82	21.80	6.90	32
Money wages and salaries, armed forces	.9	1.1	.1	70.86	88.40	.72	1
Quarters and subsistence	1.0	1.0	(1)	15.32	19.15	(1)	(2)
Self-employment income, total	12.9	13.5	10.4	875.24	993.63	401.93	40
Net income from own business	8.9	9.8	5.3	613.59	715.17	207.50	29
Net income from own farm	4.5	4.3	5.5	261.64	278.45	194.43	70
Social security and railroad income	25.0	9.5	87.0	577.61	200.56	2,085.02	1,040
Government retirement, veteran's payments, and unemployment compensation	15.2	14.4	18.6	292.65	253.19	450.40	178
Estates, trust, dividends, interest, rental income, royalties, and income from roomers and boarders, total	64.6	64.2	66.4	533.25	383.09	1,133.58	296
Rental income, royalties, income from roomers and boarders	8.6	7.6	12.7	120.87	100.90	200.71	199
Income from interest, dividends, estates, and trusts	62.7	62.6	63.3	412.38	282.19	932.87	331
Incomes from all other sources, total	68.0	72.5	50.0	600.81	576.84	696.63	121
Welfare and public assistance	6.4	5.8	9.0	107.30	108.97	100.63	92
Private pensions	5.7	2.1	20.2	129.00	48.77	449.77	922
Regular contributions for support	4.0	4.5	2.0	70.38	82.23	23.01	28
Other, including worker's compensation	61.8	69.5	31.0	294.12	336.87	123.21	37
Personal taxes, total	80.6	89.5	44.9	−1,687.93	−1,978.19	−527.51	27
Federal income taxes	75.0	85.9	31.3	−1,399.11	−1,644.64	−447.50	25
State and local income taxes	59.6	68.6	23.7	−234.05	−275.90	−66.75	24
Personal property and other personal taxes	25.6	26.5	22.1	−54.77	−57.65	−43.26	75
Other money receipts	14.0	15.0	10.2	219.41	227.38	187.56	82
Net change in assets and liabilities, total	85.5	90.6	65.1	824.23	942.02	353.31	38
Net change in assets	73.6	77.4	58.5	1,463.88	1,730.93	396.24	23
Net change in liabilities	64.4	74.9	22.5	−639.65	−788.91	−42.92	5
Goods and services received without direct expense	64.6	67.3	53.9	132.45	148.51	68.25	46
Market value of financial assets	76.6	78.0	70.9	7,094.67	5,489.73	13,511.04	246
Mortgage principal paid on owned property	35.6	42.2	9.1	−301.46	−357.85	−76.02	21

[1] Less than half the smallest quantity that can be shown.
[2] Not applicable.

Source: Bureau of Labor Statistics.

C. CONSUMER EXPENDITURES

Item	Percent reporting			Average annual amount				Percent distribution			
						65-plus				65-plus	
	All ages	Under 65	65-plus	All ages	Under 65	Amount	Percent of Under 65	All ages	Under 65	Percent	Percent of under 65
Consumption expenses, total	100.0	100.0	100.0	$9,126.73	$10,058.90	$5,400.03	54	100.0	100.0	100.0	100
Personal insurance and pensions, total	86.7	93.4	60.1	734.18	873.77	176.13	20	8.0	8.7	3.3	38
Life, endowment, annuities, income	70.9	75.7	51.9	249.11	287.19	96.88	34	2.7	2.9	1.8	62
Other personal	10.7	11.3	8.4	7.72	8.46	4.76	56	.1	.1	.1	100
Retirement and pensions	70.8	83.2	21.2	477.35	578.12	74.49	13	5.2	5.7	1.4	25
Gifts and contributions	86.6	87.3	83.9	425.70	409.69	489.72	120	4.7	4.1	9.1	222
Consumption expenses, excluding personal insurance, gifts, and contributions, total	100.0	100.0	100.0	7,966.85	8,775.44	4,734.18	54	87.3	87.2	87.7	101
Food, total	99.7	99.8	99.4	1,695.56	1,830.85	1,154.67	63	18.6	18.2	21.4	118
Food at home	99.1	99.2	98.8	1,307.62	1,388.71	983.45	71	14.3	13.8	18.2	132
Food away from home, excluding trips	87.3	92.3	67.2	369.11	420.33	164.33	39	4.0	4.2	3.0	71
Meals as pay	8.6	9.9	3.5	18.82	21.80	6.90	32	.2	.2	.1	50
Alcoholic beverages	62.7	69.2	36.9	74.80	85.98	30.12	35	.8	.9	.6	67
Tobacco products	56.5	62.0	34.4	128.50	145.71	59.70	41	1.4	1.4	1.1	79
Housing, total	99.7	99.8	99.5	2,406.95	2,619.16	1,558.56	60	26.4	26.0	28.9	111
Shelter, total	97.6	98.1	95.5	1,311.24	1,440.22	795.61	55	14.4	14.3	14.7	103
Rented dwellings	39.0	41.2	30.1	571.90	626.56	353.36	56	6.3	6.2	6.5	105
Owned dwellings	63.6	62.7	67.1	718.51	788.77	437.63	55	7.9	7.8	8.1	104
Other lodging, excluding trips	7.7	8.7	3.6	20.83	24.88	4.62	19	.2	.2	.1	50
Fuel and utilities, total	90.3	90.5	89.6	409.01	425.71	342.25	80	4.5	4.2	6.3	150
Gas, total	54.6	54.6	54.5	92.86	95.18	83.57	88	1.0	.9	1.5	167
Delivered in mains	45.2	45.5	43.9	77.64	80.37	66.71	83	.9	.8	1.2	150
Bottled or tank	10.4	10.2	11.2	15.22	14.81	16.86	114	.2	.1	.3	300
Electricity	76.1	76.3	75.3	156.80	167.39	114.45	68	1.7	1.7	2.1	124
Gas and electricity combined	13.4	13.6	12.8	40.47	42.90	30.76	72	.4	.4	.6	150
Fuel oil and kerosene	20.1	19.6	22.3	51.19	50.01	55.91	112	.6	.5	1.0	200
Other fuel, coal and wood	9.1	9.2	8.9	4.97	4.22	7.95	188	.1	(1)	.1	----
Water, trash, sewerage	62.3	62.6	61.1	62.73	66.01	49.60	75	.7	.7	.9	129
Housing expenses, total	93.6	93.7	93.3	301.16	314.90	246.21	78	3.3	3.1	4.6	148
Telephone, excluding coin phones	89.5	89.9	87.9	173.10	186.11	121.10	65	1.9	1.9	2.2	116
Other, including domestic services	68.8	68.6	69.5	128.06	128.80	125.11	97	1.4	1.3	2.3	177
House furnishings and equipment, total	88.5	91.2	77.7	385.54	438.33	174.49	40	4.2	4.4	3.2	73
Household textiles	74.3	77.9	59.9	50.82	56.05	29.90	53	.6	.6	.6	100
Furniture	41.6	46.8	20.8	131.73	153.72	43.83	29	1.4	1.5	.8	53
Floor coverings	20.8	22.9	12.3	42.21	47.12	22.58	48	.5	.5	.4	80
Major appliances	31.6	34.8	18.7	89.48	100.62	44.96	45	1.0	1.0	.8	80

Small appliances	31.6	34.9	18.4	9.77	10.88	5.34	49	.1	.1	.1	100
Housewares	25.6	28.9	12.5	9.29	10.83	3.12	29	.1	.1	.1	100
Miscellaneous	49.8	54.5	31.0	52.23	59.10	24.77	42	.6	.6	.5	83
Clothing, total	99.3	99.6	98.0	647.37	736.81	289.81	39	7.1	7.3	5.4	74
Clothing, male, age 2 plus	79.5	85.5	55.5	216.09	253.20	67.72	27	2.4	2.5	1.3	52
Clothing, female, age 2 plus	88.8	90.2	83.1	308.08	345.21	159.64	46	3.4	3.4	3.0	88
Clothing, children under 2	13.6	16.6	1.7	14.47	17.57	2.08	12	.2	.2	(1)	----
Dry cleaning and laundry	80.9	82.8	73.2	81.98	90.58	47.59	53	.9	.9	.9	100
Materials and services	62.4	65.8	49.0	26.74	30.23	12.77	42	.3	.3	.2	67
Transportation, excluding trips, total	92.5	96.1	78.1	1,578.50	1,800.83	689.43	38	17.3	17.9	12.8	72
Vehicle purchases (net outlay)	30.4	35.6	9.8	704.55	819.92	243.30	30	7.7	8.2	4.5	55
Vehicle finance charges	29.4	35.4	5.5	79.65	90.16	37.65	42	.9	.9	.7	78
Vehicle operation, total	84.5	90.2	61.9	739.34	831.94	369.17	44	8.1	8.3	6.8	82
Gasoline	83.0	88.6	60.7	347.24	395.47	154.43	39	3.8	3.9	2.9	74
Other	82.8	88.5	60.0	392.10	436.46	214.74	49	4.3	4.3	4.0	93
Other transportation	24.3	24.1	25.3	54.97	58.90	39.30	67	.6	.6	.7	117
Health care, total	96.2	95.8	97.1	473.28	479.51	448.37	94	5.2	4.8	8.3	173
Health insurance, excluding employer share	91.1	90.8	92.4	195.81	195.63	196.54	100	2.1	1.9	3.6	189
Expenses not covered by insurance	86.2	86.3	85.8	277.47	283.88	251.83	89	3.0	2.8	4.7	168
Personal care (selected)	84.2	85.7	78.4	100.22	104.78	82.00	78	1.1	1.0	1.5	150
Recreation, total	92.5	95.6	80.1	636.33	711.50	335.79	47	7.0	7.1	6.2	87
Owned vacation home	2.7	2.8	2.4	9.96	10.55	7.60	72	.1	.1	.1	100
Vacation, pleasure trips, total	62.5	67.2	43.9	249.93	263.92	193.99	74	2.7	2.6	3.6	138
Food	53.9	58.7	34.7	57.32	62.84	35.25	56	.6	.6	.7	117
Alcoholic beverages	24.7	28.3	10.3	6.96	7.95	3.01	38	.1	.1	.1	100
Lodging	35.7	39.6	20.1	41.15	41.55	39.54	95	.5	.4	.7	175
Transportation, total	60.0	64.8	40.7	86.50	91.97	64.62	70	.9	.9	1.2	133
Gasoline	53.1	58.9	30.1	32.03	36.07	15.88	44	.4	.4	.3	75
Other transportation	39.0	41.8	28.0	54.47	55.90	48.74	87	.6	.6	.9	150
All expense tours	7.7	8.0	6.7	35.08	33.61	40.96	122	.4	.3	.8	267
Other vacation expenses	38.9	43.7	19.7	22.92	26.00	10.60	41	.3	.3	.2	67
Boats, aircraft, and wheel goods	15.3	18.2	3.8	83.59	99.59	19.61	20	.9	1.0	.4	40
Other recreation, total	90.4	94.2	75.1	292.86	337.45	114.59	34	3.2	3.4	2.1	62
Television	15.8	17.5	8.9	46.54	51.24	27.73	54	.5	.5	.5	100
Other	89.7	93.7	73.7	246.31	286.19	86.86	30	2.7	2.8	1.6	57
Reading materials	84.0	86.0	76.2	47.72	51.98	30.68	59	.5	.5	.6	120
Education, total	24.2	29.3	3.9	102.53	124.65	14.10	11	1.1	1.2	.3	25
Private	10.4	12.6	1.6	62.05	75.49	8.31	11	.7	.8	.2	25
Public	16.7	20.2	2.6	40.48	49.16	5.79	12	.4	.5	.1	20
Miscellaneous	67.7	71.1	54.3	75.08	83.62	40.95	49	.8	.8	.8	100

[1] Less than half the smallest quantity that can be shown.

Source: Bureau of Labor Statistics.

23-577 O - 78 - 3

95TH CONGRESS
2d Session
SENATE
REPORT
No. 95-771

PART 1

DEVELOPMENTS IN AGING: 1977

APRIL 27 (legislative day, APRIL 24), 1978.—Ordered to be printed

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

REPORT

together with

ADDITIONAL AND SUPPLEMENTAL VIEWS

[Pursuant to S. Res. 78, and S. Res. 147, 95th Cong.]

CHAPTER I

THE FUTURE OF SOCIAL SECURITY

INTRODUCTION

Social security cash benefits (old-age, survivors, and disability insurance [1]) posed one of the most difficult challenges facing the Congress in 1977.

At stake was the soundness of trust funds from which approximately $88 billion was paid out in 1977 to almost 34 million persons ranging in age from under 1 to more than 100 years old.

The reasons for the present and future drains on the trust funds have been described in previous reports by this committee.[2]

What provided additional urgency during the past year was the realization that decisions on payroll taxes for social security would affect other decisions related to income tax reform policy.

[1] The old-age program was established in 1935 with the enactment of the Social Security Act. In 1939, coverage was provided for survivors. Disability protection was extended under the 1956 amendments for qualifying workers.

[2] See "Developments in Aging: 1976 (Pt. 1)," p. 14, and "Developments in Aging: 1975 and January-May 1976 (Pt. 1)," p. 66.

What emerged in the final days of the first session of the 95th Congress was described by the press as the highest tax hike in the peacetime history of the United States, without any dramatic improvement in benefits.[3]

The projected increases for employees and employers are so extensive that Members of Congress and others have expressed reservations about what they regard as heavy reliance on a tax often described as "regressive".

Overlooked in many of the analyses was that the overall tax increases due to be levied in the next two decades include several that were already in existence under prior law.

Nevertheless, the congressional actions on social security during 1977—projected to provide a surplus for the next 25 years and a manageable deficit for the next 75 years—raised new concerns about the reluctance to use general revenues for specific, limited purposes without damaging the fundamental wage-related feature of the program.

I. STATUS OF TRUST FUNDS BEFORE SOCIAL SECURITY FINANCING BILL

Alarm about the foreseeable shortfalls in the social security trust funds intensified during the past year. The 1977 report [4] of the Board of Trustees for the Social Security Trust Funds—old-age, survivors, and disability insurance—projected a long-range actuarial deficit at 8.20 percent of taxable payroll under the intermediate set of assumptions.[5] At that time, OASDI taxes were projected to provide income averaging 10.99 percent of taxable payroll over the 75-year period covered by the long-range actuarial cost estimates. Benefits were expected to have an average long-term cost of 19.19 percent of taxable payroll—producing a deficit of 8.20 percent of taxable payroll (19.19 percent minus 10.99 percent equals 8.20 percent).

For the short term, the Board of Trustees estimated that the reserves for the disability insurance program would be exhausted in 1979. The old-age and survivors insurance program was projected to be depleted by 1983.

This assessment was in marked contrast to the picture in 1972, when social security was in actuarial balance. A staff report prepared in 1977 for the Senate Finance Committee gave this assessment of the situation:

> The actuarial estimates made at that time—1972—showed that the program was in exact actuarial balance; that is, long-term income equaled long-term outgo. The steadily

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[3] See p. 8 for examples of benefit improvements. See p. 14 for examples of the impact of the proposed social security tax increases.

[4] "1977 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds." The Board of Trustees are the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare.

[5] The intermediate set of assumptions are based upon the following major projections: (a) Prices will rise annually by 4 percent, on the average, over the long run; (b) wages will increase by 5¾ percent per year over the long range; (c) the ultimate fertility rate (the number of children born per woman) will be 2.1; (d) the average unemployment rate will be 5 percent.

[6] For 1977, the weighted taxable payroll is about $803 billion. A deficit of 1 percent of taxable payroll would be the equivalent of approximately $8 billion at 1977 payroll levels.

deteriorating conditions which have existed from that time result in the short-run from the interaction of the economy on benefit payments and income. In the long-run, the effect of short-term conditions on long-term projections combined with the effects of changes in economic and demographic assumptions, have resulted in increases in the estimated cost of the program in relation to the anticipated income.[7]

Social security was still essentially in actuarial balance after the enactment of the two-step, 11-percent increase in 1973. The House Ways and Means Committee gave this evaluation in November 1973:

> * * * Under the tax schedule recommended by your committee, the OASDI system would have an actuarial balance of −0.51 percent of taxable payroll, which is within an acceptable limit of variation of 5 percent of the cost of the system or about 0.57 percent of taxable payroll.[8]

However, prices rose much more sharply than projected in 1973. Under intermediate assumptions used at that time, a 3.1-percent cost-of-living adjustment was projected, each, for 1975 and 1976. No social security increase was projected in 1977 because the consumer price index rise from 1976 to 1977 was expected to be less than the 3 percent needed to trigger the automatic benefit increase. But rapidly rising prices pushed cost-of-living increases up to 8 percent in 1975, 6.4 percent in 1976, and 5.9 percent in 1977. The compound effect of these three increases amounted to 21.7 percent, compared with 6.3 percent projected in 1973 for the period 1975 to 1977—or 244 percent greater than originally projected.

COST-OF-LIVING INCREASES IN BENEFITS

[In percent]

Year	1973 estimate	Actual
1975	3.1	8.0
1976	3.1	6.4
1977	[1] 0	5.9

[1] The 1973 estimates projected that the CPI rise for 1976 to 1977 would be less than the 3 percent needed to trigger an automated benefit increase.

Source: "Staff Data and Materials Relating to Social Security Financing," Senate Finance Committee, June 1977, p. 17.

Unemployment also jumped precipitously while prices soared. By the end of 1974, our Nation was in a recession which continued until 1975. In May 1975, the unemployment rate reached its highest level in 34 years. The high unemployment cut back payroll taxes for social security.

[7] "Staff Data and Materials Relating to Social Security Financing," prepared by the staff for the use of the Committee on Finance, U.S. Senate, June 1977, p. 4.
[8] H. Rept. 93-627, to accompany H.R. 11333, Nov. 9, 1973, p. 14.

INCOME AND EXPENDITURES OF THE SOCIAL SECURITY CASH BENEFITS TRUST FUNDS AS ESTIMATED IN 1973 AND IN 1977

[In billions of dollars]

Year	1973 estimate				1977 estimate			
	Income	Expenditures	Changes in funds	Funds at end of year	Income	Expenditures	Changes in funds	Funds at end of year
1973	54.8	53.4	1.4	44.2	[1] 54.8	[1] 53.1	[1] 1.6	[1] 44.4
1974	63.1	61.2	1.9	46.1	[1] 62.1	[1] 60.6	[1] 1.5	[1] 45.9
1975	68.5	67.6	.8	46.9	[1] 67.6	[1] 69.2	[1] −1.5	[1] 44.3
1976	74.8	73.1	1.7	48.6	[1] 75.0	[1] 78.2	[1] −3.2	[1] 41.1
1977	80.9	77.8	3.1	51.7	82.1	87.7	−5.6	35.5
1978	85.5	83.7	1.9	53.6	90.7	97.5	−6.9	28.6

[1] Actual rather than estimated amounts.

Note: Totals do not necessarily equal the sum of rounded components.

Source: "Staff Data and Materials Relating to Social Security Financing," Senate Finance Committee, June 1977, p. 16

In addition, demographic and economic assumptions underlying the long-range projections were substantially changed. For example, the 1973 intermediate estimate of the cash benefits program was based on the assumptions that (*a*) the ultimate fertility rate would be 2.3 to 2.8 children per woman and (*b*) the long-range productivity level (the difference between the movement of wages and prices) would be 2¼ percent. By 1976, the estimated fertility rate declined to 1.9 children per woman, and the projected productivity level was reduced to 1¾ percent.

Under a lower projected fertility rate, there would be a higher ratio of older persons collecting social security benefits to younger workers contributing to the system. With a lower productivity rate, the ratio of benefits to contributions would be higher in any given year.

II. PRESIDENT'S PROPOSED SOCIAL SECURITY CHANGES

Against this backdrop, President Carter submitted an eight-point plan to the Congress on May 9 to strengthen the financing of social security. He recommended six major actions intended to meet the short-term actuarial deficit:

(1) Use general revenues in a countercyclical fashion to replace lost payroll tax receipts when unemployment exceeds 6 percent. The proposal would apply to the period 1975 to 1982.

(2) Remove the wage base ceiling ($16,500 in 1977) for employers in three stages, so that it is completely eliminated in 1981.

(3) Increase the wage base subject to employee (or self-employment tax) by $2,400 above the levels applicable under existing law. This change would occur in four stages with $600 increases in 1979, 1981, 1983, and 1985.

(4) Shift a portion of the medicare hospital insurance tax rate to the cash benefits (old-age, survivors, and disability insurance) program, beginning in 1978.

(5) Restore the social security cash benefits tax that is paid by the self-employed to the traditional rate of 1½ times the tax on employees.

(6) Correct certain technical provisions of the Social Security Act which differentiate on the basis of sex, including a new eligibility test for dependent benefits necessitated by Supreme Court decisions (see p. 17 for additional discussion) striking down the dependency requirements for husbands and widowers to receive benefits on the basis of the wife's earnings record.

President Carter recommended two major actions to reduce the long-range actuarial deficit. First, he proposed to "decouple" the social security benefit formula.[9] Second, the Carter proposal would move forward the 1-percent social security tax rate scheduled in present law for 2011 so that 0.25 percent would become effective in 1985 and the remainder in 1990.

The administration's proposals were designed to eliminate the social security deficit for the remainder of the century. The long-range deficit would decline from 8.2 percent to 1.9 percent of taxable payroll.

Impact of administration proposals on long-range financial status of trust funds

[As percent of taxable payroll]

Deficit under present law	−8.2
Savings from decoupling	+12.0
Cost of wage-indexed benefit formula	−7.9
Effect of:	
Employer base increases	+.9
Employee base increases	+.1
Self-employed tax increase	+.1
Diversion of hospital taxes and acceleration of 2011 tax rate increase	+1.0
Dependency tests	+.1
Residual deficit	[1] −1.9

[1] While the administration's proposals would assure sufficient financing for the next 25 years or so and maintain the reserve ratio above one-third in the 1980's, they would leave a long-range deficit of 1.9 percent of taxable payroll, which is equal to about 12.6 percent of long-range expenditures, under the program as it would be modified by the administration's recommendations. The administration says that this deficit is to be studied by the Social Security Advisory Council along with other benefit adequacy questions which would change the long-range deficit.

Source: "Staff Data and Materials Relating to Social Security Financing," Senate Finance Committee, June 1977, p. 31.

For the short term (1978 to 1982), the administration recommended an additional $83 billion for the cash-benefits programs. Of this total, $56 billion would be derived from measures to raise additional revenue (e.g., additional employer and employee taxes and appropriations from general revenues). The administration also proposed reductions totaling $27 billion.

	Billions
Additional income would be provided by:	
Additional employer taxes	$20
Additional employee taxes	4
Diversion of hospital insurance taxes	7
Increase in self-employment tax rate	1
Appropriation from general revenues	14
Total	56
Reduction would be achieved by:	
Reducing the ratio of trust fund assets to expenditures from 50 percent to 35 percent	24
Adding a dependency requirement for spouses benefits	3
Total	27

Source: "Staff Data and Materials Relating to Social Security Financing," Senate Finance Committee, June 1977, p. 31.

[9] For additional discussion of "decoupling," see p. 8 of this report and p. 67 of "Developments in Aging: 1975 and January-May 1976 (pt. 1)."

III. CONGRESSIONAL ACTION IN 1977

Congress passed, in final form, the Social Security Financing Amendments on December 15, 1977, and President Carter signed the measure into law (Public Law 95–216) on December 20, 1977. The new law reduces the long-range actuarial deficit for the social security cash benefits program from 8.2 percent of taxable payroll to 1.46 percent. During the next 25 years (from 1977 to 2001), social security is projected to have a surplus of 0.97 percent of taxable payroll.

Strong opposition, however, was expressed prior, during, and after congressional consideration of the 1977 amendments. Pressure intensified for the Congress to revamp the financing of social security shortly after the measure became law (for additional discussion of proposals, see pp. 13–17). Senator Frank Church, chairman of the Senate Special Committee on Aging, gave this assessment to delegates attending a conference "The Zestful Generation: Exploding the Myths of Age" in Minneapolis on February, 3, 1978:

> It is clear now, just as I said in December when I voted against the financing proposals, that Congress must go back to the drawing board for another look at social security, even though the ink is barely dry on the new law. Representative Ullman, Chairman of the House Ways and Means Committee, has said as much in recent interviews.

Senator Pete V. Domenici, minority member of the Senate Committee on Aging, in a recent address expressed his concern "about the adverse impact this tax will have on the middle class, the business community, the level of employment, and the overall health of our national economy. I do not believe that the Senate Finance Committee and the House Ways and Means Committee gave adequate consideration to the ramifications of this measure, and I regret that the Congress, under heavy pressure from the administration moved with such haste in approving this measure."

A. Financing Provisions

The act raises additional revenue primarily through increases in the wage base and payroll tax rates for employees, employers, and self-employed persons.

Wage base for employees, employers, and self-employed persons.—The maximum taxable wage base increases, beginning in 1978, until it reaches $29,700 by 1981 for employees, employers, and self-employed persons. After 1981, the base increases annually according to the average covered earnings under social security. The conferees rejected a Senate amendment to provide a higher wage base for employers.

MAXIMUM WAGE BASE FOR EMPLOYEES, EMPLOYERS, AND SELF-EMPLOYED PERSONS

Year	Prior law	Public Law 95–216
1977	$16,500	$16,500
1978	17,700	17,700
1979	[1] 18,900	22,900
1980	[1] 20,400	25,900
1981	[1] 21,900	29,700

[1] Under prior law, the maximum wage base rises each year under the automatic increase provisions.

Tax rate increases for employees and employers.—Under prior law, the social security tax rate (5.85 percent for employees and employers each, in 1977) was scheduled to rise to 6.05 percent in 1978, increasing gradually thereafter until reaching 6.45 in 1987 and eventually 7.45 in 2011. The 1977 Social Security Financing Amendments provide increases above prior law beginning in 1979. By 1987, the rate will be 7.15 percent. And, it will eventually reach 7.65 percent in 1990.

CONTRIBUTION RATE SCHEDULES UNDER PRIOR LAW

[In percent]

Calendar year	Employees and employers, each		
	OASDI	HI	Total
1977	4.95	0.90	5.85
1978	4.95	1.10	6.05
1979–80	4.95	1.10	6.05
1981	4.95	1.35	6.30
1982–84	4.95	1.35	6.30
1985	4.95	1.35	6.30
1986–89	4.95	1.50	6.45
1990–94	4.95	1.50	6.45
1995–2000	4.95	1.50	6.45
2001–10	4.95	1.50	6.45
2011 and later	5.95	1.50	7.45

CONTRIBUTION RATE SCHEDULES UNDER PUBLIC LAW 95-216

[In percent]

Calendar year	Employees and employers, each				
	OASI	DI	OASDI	HI	Total
1977	4.375	0.575	4.95	0.90	5.85
1978	4.275	.775	5.05	1.00	6.05
1979–80	4.330	.750	5.08	1.05	6.13
1981	4.525	.825	5.35	1.30	6.65
1982–84	4.575	.825	5.40	1.30	6.70
1985	4.750	.950	5.70	1.35	7.05
1986–89	4.750	.950	5.70	1.45	7.15
1990 and later	5.100	1.100	6.20	1.45	7.65

Tax rate for self-employed.—The 1977 amendments restore the self-employment tax rate for cash benefits (old-age, survivors, and disability insurance) to the original ratio of 1½ times the employee rate, effective in 1981.

CONTRIBUTION RATE SCHEDULES UNDER PRIOR LAW

[In percent]

Calendar year	Self-employed persons		
	OASDI	HI	Total
1977	.7	0.90	7.90
1978	7	1.10	8.10
1979–80	7	1.10	8.10
1981	7	1.35	8.35
1982–84	7	1.35	8.35
1985	7	1.35	8.35
1986–89	7	1.50	8.50
1990–94	7	1.50	8.50
1995–2000	7	1.50	8.50
2001–10	7	1.50	8.50
2011 and later	7	1.50	8.50

CONTRIBUTION RATE SCHEDULES UNDER PUBLIC LAW 95-216

[In percent]

Calendar year	Self-employed persons				Total
	OASDI	DI	OASDI	HI	
1977	6.1850	0.8150	7.00	0.90	7.90
1978	6.0100	1.0900	7.10	1.00	8.10
1979-80	6.0100	1.0400	7.05	1.05	8.10
1981	6.7625	1.2375	8.00	1.30	9.30
1982-84	6.8125	1.2375	8.05	1.30	9.35
1985	7.1250	1.4250	8.55	1.35	9.90
1986-89	7.1250	1.4250	8.55	1.45	10.00
1990 and later	7.6500	1.6500	9.30	1.45	10.75

B. "Decoupling" and "Wage Indexing"

The cost-of-living adjustment mechanism was overly sensitive to wage and price changes. The 1977 amendments "decouple" the cost-of-living adjustment mechanism. Benefits will increase proportionately with rising prices (as under existing law) for individuals already on the benefit rolls. Future retirees will have their benefits determined on the basis of their previous wages after those wages have been adjusted (wage indexing) to reflect annual increases in average earning levels up to the second year before eligibility (age 62, death, or disability). This will assure that similarly situated workers, generation to generation, will, on the average, receive relatively the same level of benefits at retirement (as a percent of their immediate pre-retirement earnings).

C. Benefit Provisions

Public Law 95-216 makes several changes in benefit provisions. Most liberalizations have relatively low long-term costs as a percent of taxable payroll. Some measures, though, cut back on protection.

Special minimum beneficiaries.—The act (1) authorizes cost-of-living protection for special minimum monthly beneficiaries and (2) increases the multiple for computation from $9 to $11.50. Under present law, this benefit is computed by multiplying $9 by the number of years of covered employment above 10 but not greater than 30. Thus, the maximum payment for special minimum beneficiaries will be increased from $180 to $230 a month, beginning in 1979, with further increases in future years.

Delayed retirement credit.—The delayed retirement credit is increased from 1 to 3 percent per year beginning at age 65 and taking account of months up to age 72 for which benefits are not paid because of excess earnings. The worker's credit is also applicable to widow's (or widower's) benefits.

Divorced spouses.—The duration of marriage requirement for aged divorced spouse's benefits will be reduced from 20 to 10 years.

No reduction in benefits because of remarriage.—Remarriage after age 60 will not reduce benefits paid to aged widows or widowers.

Minimum benefit freeze.—The minimum benefit will be frozen at the January 1979 level (estimated at about $121 per month) and then will increase with prices only after a person starts receiving the benefit.

Offset in benefits for dependent or surviving spouses.—Social security benefits will be reduced for dependent spouses (including surviving spouses) by the amount of any Government retirement benefit earned by the spouse in non-social-security employment. This provision becomes effective for persons who first apply for their benefits as dependent spouses after November 30, 1977. An exemption is also provided for Government employees who become eligible during the next 5 years for their Government pension, but only if they meet the requirements of social security entitlement in effect on January 1977.

National Commission on Social Security and Special Consumer Price Index for the Aged.—A nine-member National Commission on Social Security is established, jointly appointed by the President and the Congress, to conduct a comprehensive 2-year study of social security. The commission would also consider the need for a special consumer price index for the elderly.

Limitation on retroactive benefits.—Payment of retroactive benefits will be prohibited when it will result in permanently reduced social security benefits. Under prior law, a person filing an application for benefits after first becoming eligible can receive benefits for a retroactive period up to 12 months, if all conditions of entitlement are met for those months. Retired workers receiving social security at ages 62, 63, or 64 have their benefits actuarially reduced for each year before age 65.

Cost-of-living increases for early retirees.—An early retiree who begins to receive benefits between ages 62 and 65 has his monthly payment reduced permanently on an actuarial basis to take account of the longer period that he receives benefits on the average. Under prior law, an early retiree received a cost-of-living increase after attaining age 65 as though he were drawing a full benefit. Public Law 95–216 applies to cost-of-living increases for early retirees the same actuarial reduction that is applied to their original monthly benefit.

D. Earnings Limitation, or "Retirement Test" [10]

In 1977, social security beneficiaries under age 72 could earn up to $3,000 per year before $1 in benefits would be withheld for each $2 of earnings above this ceiling. Public Law 95–216 raises the annual earnings limitation before benefits are reduced for persons aged 65 to 71 to $4,000 in 1978, $4,500 in 1979, $5,000 in 1980, and $5,500 in 1981. Beginning in 1982, the retirement test is abolished completely for persons 70 or older. In 1982, the earnings ceiling will increase to $6,000 for persons 65 or older, and then it will be adjusted automatically annually on the basis of average covered earnings under social security. As under prior law, the annual exempt earnings limitation for beneficiaries under age 65 will be adjusted automatically each year, reaching a projected level of $4,200 in 1982. The monthly measure of retirement—permitting payment of social security benefits in any month a person earns one-twelfth of the retirement test or less—is eliminated. However, the monthly measure is retained for the first year that a worker begins to receive retirement benefits.

[10] Social security is a social insurance program designed to protect workers and their families from loss of earnings because of retirement, death, or disability. An earnings limitation is imposed to determine whether, in fact, a beneficiary has suffered a loss in earnings because of retirement.

E. Coverage

The Secretary of Health, Education, and Welfare is directed to conduct a study in cooperation with other Federal agencies concerning mandatory social security coverage for Federal, State, and local employees. The report is due within 2 years of enactment of the Social Security Financing Amendments of 1977.

F. Status of the Cash Benefits Trust Funds

The 1977 amendments strengthen the financing of the cash benefits trust funds. The balance for the old-age and survivors insurance program is projected to grow from $32.3 billion at the end of 1977 to $115.9 billion in 1987. For the disability insurance program, the trust fund balance is expected to increase from $3.3 billion in 1977 to $25.1 billion in 1987. The following tables provide a summary of the condition of the cash benefits trust funds.

ESTIMATED OPERATIONS OF THE OASI TRUST FUND UNDER THE PROGRAM AS MODIFIED BY PUBLIC LAW 95-216, CALENDAR YEARS 1977-87

[Dollar amounts in billions]

Calendar year	Income	Outgo	Net increase in fund	Fund at end of year	Fund at beginning of year as a percentage of outgo during year	Fund at end of year as a percentage of outgo during year
1977	$72.5	$75.6	−$3.1	$32.3	47	43
1978	78.6	83.6	−5.0	27.3	39	33
1979	90.8	91.6	−.8	26.5	30	29
1980	101.5	100.0	1.5	28.0	26	28
1981	116.0	108.4	7.5	35.6	26	33
1982	127.2	117.4	9.7	45.3	30	39
1983	136.6	126.3	10.3	55.6	36	44
1984	146.4	136.0	10.5	66.1	41	49
1985	162.0	146.4	15.7	81.7	45	56
1986	174.1	157.3	16.8	98.5	52	63
1987	186.3	168.9	17.4	115.9	58	69

Note: The above estimates are based on the intermediate set of assumptions shown in the 1977 trustees report.

Source: Social Security Administration, Office of the Actuary, December 1977.

ESTIMATED OPERATIONS OF THE DI TRUST FUND UNDER THE PROGRAM AS MODIFIED BY PUBLIC LAW 95-216 CALENDAR YEARS 1977-87

[Dollar amounts in billions]

Calendar year	Income	Outgo	Net increase in fund	Fund at end of year	Fund at beginning of year as a percentage of outgo during year	Fund at end of year as a percentage of outgo during year
1977	$9.6	$12.0	−$2.4	$3.3	48	27
1978	13.8	13.7	.2	3.5	24	25
1979	15.7	15.3	.4	3.9	23	26
1980	17.6	17.1	.5	4.4	23	25
1981	21.1	19.0	2.1	6.5	23	34
1982	23.0	20.9	2.1	8.6	31	41
1983	24.7	22.9	1.8	10.4	38	45
1984	26.5	25.2	1.3	11.6	41	46
1985	32.1	27.7	4.5	16.1	42	58
1986	34.9	30.3	4.6	20.8	53	69
1987	37.4	33.1	4.3	25.1	63	76

Note: The above estimates are based on the intermediate set of assumptions shown in the 1977 trustees report.

Source: Social Security Administration, Office of the Actuary, December 1977.

ESTIMATED OPERATIONS OF THE OASI AND DI TRUST FUNDS, COMBINED, UNDER THE PROGRAM AS MODIFIED BY PUBLIC LAW 95-216, CALENDAR YEARS 1977-87

[Dollar amounts in billions]

Calendar year	Income	Outgo	Net increase in fund	Fund at end of year	Fund at beginning of year as a percentage of outgo during year	Fund at end of year as a percentage of outgo during year
1977	$82.1	$87.6	−$5.5	$35.6	47	41
1978	92.4	97.2	−4.8	30.8	37	32
1979	100.5	106.9	−.4	30.4	29	28
1980	119.1	117.1	2.0	32.4	26	23
1981	137.1	127.4	9.6	42.0	25	38
1982	150.2	138.3	11.9	53.9	30	39
1983	161.3	149.2	12.1	66.0	36	44
1984	172.9	161.2	11.7	77.7	41	48
1985	194.2	174.0	20.1	97.9	45	56
1986	209.0	187.6	21.4	119.3	52	64
1987	223.7	202.0	21.7	141.0	59	70

Note: The above estimates are based on the intermediate set of assumptions shown in the 1977 trustees report.

Source: Social Security Administration, Office of the Actuary, December 1977.

IV. ISSUES REQUIRING ADDITIONAL ATTENTION

Public Law 95-216 is intended to place the social security system on a sound basis through the beginning of the next century. But many questions still exist, and a host of other issues have arisen. Among the major issues requiring additional attention by the 95th Congress or future Congresses:

A. Independent Social Security Administration

Social security affects almost every American family in the United States. More than 90 percent of all persons 65 or older are eligible for social security. Approximately 80 percent of all men and women 21 to 64 years old are protected in the event a family breadwinner suffers a long-term disability. And 95 percent of all mothers and dependent children are eligible for benefits if the father in the family dies.

Every one of these individuals has a very direct and important stake in the financial soundness of social security and the way it is administered. They deserve effective and efficient service from social security offices throughout the country.

On March 31, 1977, Senator Church introduced the Social Security Administration Act, S. 1194, to assure that the social security system continues to be administered effectively, impartially, and efficiently. Representative Charles Vanik, Chairman of the Oversight Subcommittee of the House Ways and Means Committee, introduced a companion bill (H.R. 5900).

The Social Security Administration Act has three principal provisions:

(1) The Social Security Administration would be reestablished as an independent, nonpolitical agency under the direction of a three-member governing board, appointed by the President with the advice and consent of the Senate.

(2) Notices accompanying social security or supplemental security income checks could not make reference to elected public officials.

(3) The transactions of the social security trust funds would be removed from the unified budget. Social security trust funds, though, would still be taken into account for purposes of economic analysis, as has always been the case.

Senator Church gave this rationale[11] for independent status:

—A separate SSA would help to reduce the Department of HEW to more manageable proportions.

—A three-member governing board—appointed for staggered terms—would permit continuity of operation. Senator Church added, "This would be a safeguard against the situation which occurred in 1973, when the Social Security Administration operated without a Commissioner at the helm for about 7 months. During this time, crucial decisions affecting the supplemental security income program had to be made. I am convinced that this gap contributed to some of the problems now confronting SSI."[12]

—Some degree of specialization would be possible with a three-member governing board. Members could, for example, be specialists in a particular area, such as cash benefits or SSI.

—The rapid turnover of HEW Secretaries (12 Secretaries during HEW's 24 years of existence) creates problems for the operation of social security.

B. Treatment of Women Under Social Security

Major questions still exist about the treatment of women under social security, whether they be homemakers or working wives. Women complain with greater frequency that their contributions cannot generate as much in benefits for family members as can the contributions of men.

On November 17, 1977, Secretary of HEW Joseph Califano appointed a nine-member task force on the treatment of women under the Social Security Act. Former Social Security Commissioner James B. Cardwell is the chairperson of the departmental task force. The advisory body is responsible for preparing a comprehensive and objective report on the treatment of women under social security. A major purpose of this study is to facilitate the Social Security Advisory Council's consideration of this subject.

Specific areas of concern for the task force include (1) treatment of married women who do not work, (2) treatment of single workers, (3) protection for divorced women, and (4) equity for individual workers versus protection for families.

Public Law 95–216 directs the Secretary of HEW to conduct a study of changes needed to guarantee that women, as well as men, are treated equitably under social security. The study is to be completed and a report submitted to Congress within 6 months after enactment of the 1977 Social Security Financing Amendments.

C. Improving Social Security Cost-of-Living Protection

Social security beneficiaries now receive an automatic cost-of-living adjustment in July, provided the Consumer Price Index rises by at

[11] See Senator Church statement beginning on p. S5276, Mar. 31, 1977 Congressional Record.
[12] Page S5277 of Congressional Record cited in footnote 11.

least 3 percent from the first quarter (January, February, and March) in the preceding year to the first quarter in the present year. The Congress can, of course, enact a general benefit increase in lieu of the automatic cost-of-living adjustment.

In 1977, the House and Senate each took steps to strengthen the automatic escalator provision. One measure became law, and the other proposal was dropped in conference committee. House and Senate conferees agreed to a House-passed provision to extend automatic cost-of-living protection to special minimum beneficiaries (see p. 8 for more discussion). However, the conferees rejected the Church-Domenici-Clark amendment [13] to provide semiannual cost-of-living increases for social security beneficiaries during periods of rapid inflation.

The amendment would authorize semiannual cost-of-living adjustments—in January and July—provided the inflationary index increased by at least 4 percent semiannually from one benefit period to another. The measuring period would be from February to August to determine whether social security beneficiaries would be entitled to a cost-of-living increase in January, and from August to February for any possible July increase. If the Consumer Price Index would not increase by 4 percent within a 6-month measuring period, social security beneficiaries would eventually receive a cost-of-living adjustment when prices rise by at least 3 percent since the last increase.

Major arguments for the adoption of the amendment include:

—Semiannual cost-of-living adjustments would allow social security benefits to be kept more current with rising prices during periods of accelerated inflation.

—Civil service annuitants receive two cost-of-living increases a year.

—A once-a-year cost-of-living adjustment may be too little and too late for social security beneficiaries during periods of rapid inflation.

—The long range cost of the amendment would be low: 0.03 percent of taxable payroll.

—No short-term cost is projected because there is no anticipated period when the semiannual mechanism would be triggered.

Opponents contend:

—The amendment should not be adopted until hearings have been held.

—The cost of the amendment would be greater than projected if our Nation experienced a sustained period of inflation.

D. Alternative Financing Arrangements

The Social Security Financing Amendments of 1977 raise payroll taxes by $227 billion from 1979 to 1987. Payroll taxes are projected to increase by 216 percent for workers with maximum covered earnings between 1977 ($965.25) to 1987 ($3,045.90). Compared with the tax rate and maximum wage base scheduled under prior law for 1987, Public Law 95–216 increases payroll taxes for a worker with

[13] Forty-four Senators sponsored the Church-Domenici-Clark amendment. Other sponsors include Senators Williams, Pell, Stafford, Humphrey, Abourezk, Hatfield, Riegel, Randolph, Stone, McIntyre, Eastland, McGovern, Metcalf, Melcher, Bumpers, Leahy, Cannon, Anderson, Brooke, Thurmond, Bayh, Hart, Kennedy, Magnuson, Weicker, Sarbanes, DeConcini, Heinz, Chiles, Case, Jackson, Haskell, Durkin, Javits, Hollings, Percy, Ford, Metzenbaum, Biden, Burdick, and Hathaway.

maximum covered earnings by 51 percent. Precise figures are not available at this time, but only a small proportion of all workers are expected to earn $42,600 or more a year in 1987.

CURRENT AND PROPOSED SOCIAL SECURITY TAXES COMPARED

Year	Current law			Conference bill		
	Tax rate (percent)	Wage base	Maximum tax	Tax rate (percent)	Wage base	Minimum tax
1977	5.85	$16,500	$965.25	5.85	$16,500	$965.25
1978	6.05	17,700	1,070.85	6.05	17,700	1,070.85
1979	6.05	18,900	1,143.45	6.13	22,900	1,403.77
1980	6.05	20,400	1,234.20	6.13	25,900	1,587.67
1981	6.30	21,900	1,379.70	6.65	29,700	1,975.05
1982	6.30	23,400	1,474.20	6.70	31,800	2,130.60
1983	6.30	24,900	1,568.70	6.70	33,900	2,271.30
1984	6.30	26,400	1,663.20	6.70	36,000	2,412.00
1985	6.30	27,900	1,757.70	7.05	38,100	2,686.05
1986	6.45	29,400	1,896.30	7.15	40,200	2,874.30
1987	6.45	31,200	2,012.40	7.15	42,600	3,045.90

Note: Under current law, the tax rate through 1987 and the wage base through 1978 are set by statute; the wage base after 1978 is estimated under an automatic escalator provision. Under the conference bill, the tax rate through 1987 and the wage base through 1981 would be set by statute; the wage base after 1981 is estimated.

Source: Wall Street Journal, Dec. 17, 1977, p. 3.

In 1982, a worker with maximum covered earnings (projected at $31,800) would pay $2,130.60 in social security taxes, compared with $1,474.20 projected for a worker with maximum earnings under prior law. Less than 6 percent of all covered workers are expected to be earning $31,800 or more in 1982. Persons with higher earnings will also receive improved retirement, disability, and survivor protection for themselves and their families.

For lower and moderate-income wage earners, the payroll tax bite is less severe. The following table provides illustrations:

Wage earner	1977		1982		1987	
	Prior law	1977 amendments	Prior law	1977 amendments	Prior law	1977 amendments
$10,000	$585.00	$585.00	$630	$670	$645.00	$715.00
$15,000	877.50	877.50	945	1,005	967.50	1,072.50

For the $10,000 wage earner, payroll taxes in 1987 will be $70 higher under Public Law 95–216 than under prior law, and $130 above the 1977 level (or a little more than $2.50 per week). A $15,000 wage earner will pay $105 more in 1987 under the social security financing amendments than under prior law, and $195 above the 1977 level.

Growing resistance to rising social security taxes is clearly evident from many quarters: Employers, employees, and others. Increasingly, legislators and opinion leaders are suggesting alternative financing methods. Tom Wicker, of the New York Times, proposed that general revenues should finance 25 to 45 percent of the social security program, giving this rationale:

> Most of the planners of the American social security originally envisioned, when doing their work in the 1930's, that sometime in the 1960's it would become necessary to put general fund revenues into the system. What's more, the Federal

> Government has been matching all medical insurance contributions, to the medicare system since 1965. Where's the difference in principle? Yet, Congress remains wedded to the myth that to support social security with general revenues would convert it to "welfare." [14]

Other suggestions have also surfaced, including:

—Use general revenues to finance a portion or all of the medicare hospital insurance program and then reduce the cash benefits contribution rate by the amount of the reduction in the tax rate for hospital insurance.

—Bring all Government employees under social security.

—Draw upon the excise tax for cigarettes and alcoholic beverages to finance a portion of medicare or other designated health care program for the aged and disabled.

Legislative efforts to hold down or roll back the 1977 social security tax increases gained powerful momentum in the early months of 1978. In February, the House Ways and Means Committee came within one vote (rejected 19 to 18) of recommending a $3.6 billion payroll tax reduction and making an offsetting cutback in the income tax reduction proposed by President Carter. The close vote came on the Ways and Means Committee's recommendations to the Budget Committee setting forth revenue and spending targets for fiscal year 1979 (October 1, 1978 to September 30, 1979).

Members of Congress also introduced several bills to provide general revenue financing for portions of the social security system. One example is H.R. 10668—introduced by Representative James Burke, chairman of the Ways and Means Subcommittee on Social Security. H.R. 10668 would (1) reduce the social security tax rate for employers and employees (each) from 6.13 percent to 3.90 percent in 1979; (b) increase the taxable wage base to $100,000 in 1979; and (3) provide a one-third contribution from general revenues for the social security system. Representative Burke set a goal of 250 cosponsors for his bill. He said in a letter to House and Senate members:

> Social security has enjoyed long-standing public acceptance and support. It is a vital arm of our national policy of income security and dignity for the retired and disabled. Unfortunately, we jeopardize the future acceptance and viability of this great social experiment by exacting too high a cost for its financing. Already the working public is increasingly alarmed by present social security tax rates. This displeasure will build tremendously in the decade ahead when the social security tax, even now the largest tax for over 50 percent of America's households, increases dramatically.

Senator Nelson introduced the Social Security Refinancing Act (S. 2503) on February 6. S. 2503 would remove the disability insurance and hospital insurance programs from the payroll tax and substitute general revenue financing for these programs. The Nelson proposal would reduce the social security tax rate from 6.13 percent in 1979 to 4.3 percent. The rate would rise to 4.4 percent in 1980 and remain at that level until 2005, when it would increase to 4.6 percent.

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[14] New York Times, Dec. 13, 1977, p. 43.

SOCIAL SECURITY TAX RATES AND WAGE BASE UNDER PRESENT LAW AND THIS PROPOSAL

Year	Employee/employer tax rate		Self-employed tax rate		Wage base	
	Present law [1] (percent)	This proposal [2] (percent)	Present law [1] (percent)	This proposal [2] (percent)	Present law	This proposal
1978	6.05	6.05	8.1		$17,700	[3]
1979	6.13	4.3	8.1	6.45	22,900	[3]
1980	6.13	4.3	8.1	6.45	25,900	[3]
1981	6.65	4.4	9.3	6.6	29,700	[3]
1982	6.70	4.4	9.35	6.6	31,800	[3]
1983	6.70	4.4	9.35	6.6	33,900	[3]
1984	6.70	4.4	9.35	6.6	36,000	[3]
1985	7.05	4.4	9.90	6.6	38,100	[3]
1986	7.15	4.4	10.00	6.6	40,200	[3]
1987	7.15	4.4	10.00	6.6	42,000	[3]
1990	7.65	4.4	10.75	6.6	[4]	[3]
1995	7.65	4.4	10.75	6.6		[3]
2005	7.65	4.6	10.75	6.9		[3]
2015	7.65	5.4	10.75	8.1		[3]
2025	7.65	6.8	10.75	10.2		[3]
2035	7.65	6.8	10.75	10.2		[3]
2045	7.65	6.8	10.75	10.2		[3]
050	7.65	6.8	10.75	10.2		[3]

[2]

[1] Tax rate supports OASI, DI, and HI trust funds.
[2] Tax rate supports OASI trust fund only.
[3] Same as present law.
[4] Wage base increases in response to increase in average wage levels.

EMPLOYER/EMPLOYEE SOCIAL SECURITY TAX LIABILITY UNDER PRIOR LAW, CURRENT LAW, AND THIS PROPOSAL

	1979			1982			1985			1987		
	Prior law	Current law	This proposal	Prior law	Current law	This proposal	Prior law	Current law	This proposal	Prior law	Current law	This proposal
Average earnings:												
$10,000	$605	$613	$433	$630	$670	$440	$630	$705	$440	$645	$715	$440
$15,000	908	920	650	945	1,005	660	945	1,058	660	968	1,073	660
$20,000	1,143	1,226	866	1,260	1,340	880	1,260	1,410	880	1,290	1,430	880
$25,000	1,143	1,404	992	1,474	1,675	1,100	1,575	1,763	1,100	1,613	1,788	1,100
$30,000	1,143	1,404	992	1,474	2,010	1,320	1,758	2,115	1,320	1,935	2,145	1,320
$40,000	1,143	1,404	992	1,474	2,131	1,399	1,758	2,686	1,676	2,012	2,850	1,760

Senator Domenici introduced legislation on March 14, S. 2741, which would allow a refundable tax credit to offset future social security tax increases. Senator Domenici stated:

> This approach is simple, direct, and easy to administer. It is not an economic "shell game" which seeks to redistribute income. It does not require a new or enlarged bureaucracy to administer and it will give direct relief to the people who pay the increased tax burden. Individuals who earn less than $17,700 (the wage base for social security in 1977) will receive a dollar-for-dollar credit for all increases in the social security tax rate above 5.85 percent. Thus a credit of 0.20 percent would be allowed in tax year 1978, 0.28 percent in 1980, 1.20 percent in 1985, and 1.80 percent in 1990 for individual employees and employers. Self-employed individuals would receive relief as their tax rises above 7.90 percent. Individuals whose earnings exceed the social security wage base will receive relief from increases in the tax rate but it will fall somewhat short of dollar-for-dollar relief because of

the rise in the wage base. Although the relief for individuals in this category will be somewhat less than total—it will still be much more complete than the administration's approach.

My proposal will benefit the economy and individual taxpayers in three important ways. First, it is a refundable credit, thus it will offer relief to persons with little or no tax liability. Second, it provides relief for the hard pressed self-employed. Third, it provides relief for employers who might otherwise reduce the number of their employees in an effort to cut personnel costs. The tax burden on all businesses, and small businesses in particular, have reached to a point where employment levels and the future health of an important sector of our economy is being threatened.

According to Dr. Arthur Okum of the Brookings Institute: "This tax credit will reduce the regressive tax on employees and the inflationary impact on employers due to the recent social security tax increase, thus making a better tax system."

V. COURT DECISIONS AFFECTING SOCIAL SECURITY

As has been seen, 1977 produced major initiatives and actions by the executive branch and the Congress affecting social security financing and benefit levels. Federal courts also issued some potentially far-reaching decisions, especially affecting the treatment of men and women under social security. Among the key holdings:

A. Support Requirement for Widowers and Widows

On March 2, 1977, the Supreme Court (*Califano* v. *Goldfarb*, 430 U.S. 199) declared unconstitutional the requirement that a widower must receive one-half of his support from his wife at the time of her death in order to become entitled to benefits on the earnings record of his spouse. A widow, on the other hand, is presumed to be dependent upon her husband. On March 21, 1977, the Supreme Court (*Califano* v. *Silbowitz, Califano* v. *Jablon, Califano* v. *Abbott*, 430 U.S. 924) declared unconstitutional a similar provision pertaining to husbands.

B. Age-62 Computation Point for Men

On March 21, 1977, the Supreme Court (*Califano* v. *Webster*, 97 S. Ct. 1192) reversed a decision of the District Court for the Eastern District of New York. The district court had held that the formula used to compute male wage earners' benefits prior to 1975 violated the equal protection clause of the Constitution. Prior to the 1972 Social Security Amendments, retirement benefits for men were figured differently than for women. For retired male workers, benefits were generally computed on the basis of earnings averaged over a number of years equal to the number elapsing after 1950 and before age 65. But benefits for women workers were based on the number of years up to age 62. This, in effect, gave them three additional low-earning dropout years. The 1972 Social Security Amendments provided for an age 62 computation point for men to be fully effective in January 1975 by reducing the age for men to 64 in 1973, to 63 in 1974, and to

62 in 1975. The Supreme Court held that gender-based distinctions prior to 1975 are constitutional if they are related to governmental objectives to correct the disparity in the economic conditions between men and women.

C. Judicial Review and Administrative Finality

On February 23, 1977, the Supreme Court (*Califano* v. *Sanders*, 97 S. Ct. 980) held that the Administrative Procedures Act does not confer jurisdiction on the district court to review final actions of the Secretary of Health, Education, and Welfare. The Administrative Procedures Act generally provides for judicial review of actions of Federal agencies. The Supreme Court held that judicial review of the Secretary's final actions are conferred solely by the Social Security Act (sec. 205 (g)).

D. Hearing Delays

On July 18, 1977, the Court of Appeals for the Second Circuit (*Califano* v. *White*, 559 F. 2d 852) affirmed the decision of the District Court for the District of Connecticut, ordering the Social Security Administration to hold a disability hearing and issue a decision in the State of Connecticut in 180 days by July 1, 1977; 150 days by December 31, 1977; and 120 days by July 1, 1978. The Social Security Administration must begin payments to a claimant if these time limits are exceeded. These payments are overpayments if the claimant is found ineligible after a hearing.

E. Divorced Husbands' Benefits

In June 1977, the District Court for the Northern District of California (*Oliver* v. *Mathews*, C. 76-2397-WHO), declared unconstitutional the provision in the Social Security Act authorizing benefits for qualifying divorced wives of insured male workers, but not for similarly situated divorced husbands of insured female workers. The Department of HEW is not appealing the holding, and SSA is implementing the decision.

FINDINGS AND RECOMMENDATIONS

More than 33 million social security beneficiaries received a 5.9-percent cost-of-living increase in July 1977. This adjustment raised average monthly benefits from $221 to $234 for retired workers, from $377 to $400 for aged couples, and from $210 to $223 for elderly widows. The minimum monthly benefit for a retired worker 65 years or older increased from $107.90 to $114.30. The maximum benefit for a male worker retiring in 1977 at age 65 rose from $412.70 to $437.10.

Social security is the economic backbone for the vast majority of older Americans. It accounts for more than half the income for 7 out of 10 individual beneficiaries and 1 out of 2 elderly couple beneficiaries.

In addition, social security keeps 10 million persons out of poverty, including 7 million older Americans. Without these benefits, millions of elderly individuals would be forced onto the welfare rolls. Others would be required to depend upon relatives—many of whom would be financially hard pressed to provide economic assistance. Without social security, the overwhelming proportion of older Americans could not hope to achieve even a moderate standard of living.

These facts underscore the importance of social security for practically every American family—as well as the need to assure that it is financially sound and effectively administered.

The committee recommends that the following actions should be taken to strengthen social security:

—The existing Social Security Administration should be reconstituted as an independent, nonpolitical agency under the direction of a three-member governing board.*

—There should be an outright ban on the mailing of political notices—or anything resembling political announcements—with social security checks.

—Social security beneficiaries should be entitled to semiannual cost-of-living adjustments during periods of rapid inflation.*

—Alternative financing arrangements should be considered by appropriate congressional units to ease the steep social security tax hikes scheduled in the 1980's for employees, employers, and self-employed persons.

Corrective action should also be taken to assure that social security cost-of-living increases will not cause a reduction in benefits for veterans pensions and other Federal benefit programs.

**Members of the Senate Committee on Aging had a divided opinion on these two recommendations. Senators Church, Glenn, DeConcini, Melcher, and Brooke favored printing them in this report. Senator Muskie also approved, but submitted additional views (see page 25). Senators Domenici, Chiles and Percy favored complete deletion of these two recommendations.*

CHAPTER II

MANDATORY RETIREMENT, INCOME, AND EMPLOYMENT

Mandatory retirement became the target in 1977 of determined efforts to end the practice once and for all or to take long steps toward that goal.

The House of Representatives took early and decisive action in September by passing legislation to raise the age limit in the 10-year-old Age Discrimination in Employment Act (ADEA) from 65 to 70 while, at the same time, ending retirement at fixed ages in the Federal service.

Soon after, the Senate took similar action on the ADEA age limit, but added two exemptions to which the House objected strenuously. The Senate bill did not deal, either, with forced Federal retirement.

Unable to resolve differences, House and Senate conferees continued their discussions in 1978 and agreed on a compromise plan declared by its supporters to be landmark legislation certain to change lifetime work patterns in the United States.

Congressional action was accompanied elsewhere in the Nation by other assaults on mandatory retirement, including legislation in California and Maine, a referendum in Los Angeles, and an executive order in Seattle.[1]

These breakthroughs occurred as the Congress and the administration took actions in other areas related to income and employment, including:

—A social security financing package to bring the cash benefits program into actuarial balance. (See chapter I for details.)

—A welfare reform package with important implications for supplemental security income recipients. (See section III of this chapter.)

—A more than doubling of the funding for the title IX senior community service employment program.

—Abolition of the social security earnings limitation (also called the retirement test) for persons 70 or older (reduced from age 72), effective in 1982.

Some of these actions have already had an impact on the lives of aged and aging Americans, particularly the increased funding for senior community service employment.

[1] The Maine Legislature, in enacting L.D. 1634, "An Act to Prohibit the Practice of a Mandatory Retirement Age," abolished mandatory retirement by July 1, 1978, for all State, local, and municipal employees, including public safety officers and staff at the University of Maine. It also commissions the State planning office and the Maine Committee on Aging to conduct a study for report in 1979 to the next legislature with recommendations for abolishing mandatory retirement in the private sector in 1980. In California, Governor Brown signed bills in October 1977 which abolish mandatory retirement for most employees in the public and private sectors. The Seattle and Los Angeles actions apply to muncipal employees.

But the future effect may be much greater, particularly the ramifications from a new ceiling on mandatory retirement which matches the new age for the social security retirement test.

I. RETIREMENT AS A CHOICE, NOT AS A "MUST"

> "Unrealistic employment or retirement policies create unnecessary problems for the individual, the family, and the community. For the individual, such policies set him as apart from the rest of society and classify him as a nonproductive member. They deny him the satisfaction of full participation in community life and may prevent him from being financially independent. Arbitrary retirement policies, coupled with the denial of work opportunity, may also seriously threaten the health of the individual concerned."
>
> —American Medical Association, 1977.[2]

> ". . . employers are looking at age instead of the person."
>
> —From resolution adopted by Mountain Plains Congress of Senior Organizations, Denver, Colo., August 1977.

A report [3] prepared for the Senate Committee on Aging in 1977 gave the following reasons for the growing challenge to mandatory retirement:

—A longer average life expectancy.
—Improved health and health-care techniques.
—The desire to maintain previous gains in the standard of living.
—Growing recognition of the detrimental effects of enforced idleness.
—The concept of age as a civil right.
—Inflation as more than a transitory phenomenon.[4]

Focus on ADEA: As enacted in 1967, the Age Discrimination in Employment Act extended its protection "to individuals who are at least 40 years of age but less than 65 years of age."

This upper limit became the focal point for corrective action during 1977 in both Houses of the Congress.

Senator Pete Domenici, for example, gave these arguments when introducing a bill (S. 481[5]) on January 28, 1977:

> By specifically exempting from the protection of the act those workers who are 65, Congress appears to sanction discrimination against the older worker. The act appears to be saying that, while one may not discriminate against workers who are between 40 and 65, one may quite properly, with the

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[2] In letter from James H. Sammons, M.D., executive vice president, A.M.A., to Carl D. Perkins, chairman, House Committee on Education and Labor, August 22, 1977.

[3] *The Next Steps in Combatting Age Discrimination in Employment: With Special Reference to Mandatory Retirement Policy,* August 1977, by Marc Rosenblum. This working paper includes: a discussion of the ADEA's effectiveness, including summaries of related court decisions; pros and cons of ending mandatory retirement; and suggestions for legislative actions. Another useful summary of issues related to mandatory retirement is "Mandatory Retirement," by Sharon House, Congressional Research Service, Library of Congress, revised May 5, 1977.

[4] Page 14, report cited in footnote 3. The relationship of retirement practices to job openings for middle-aged and older workers received special attention in the report, which said at one point: "It is one thing to ban age discrimination in employment. It is another to broaden work opportunities for older men and women in order to reduce pressure for them "to make way for younger workers." (See next section of this chapter for additional discussion of older worker problems and advances.)

[5] S. 481 provided for the complete elimination of the 65-year limitation.

> full permission of the Congress, discriminate against those workers who have passed their 65th birthday.
>
> The present law is capricious, arbitrary, and often misused. We should not be willing to sacrifice the older worker on the altar of high unemployment. If we are to expand job opportunities for our growing labor force, let us use more humane and rational economic means rather than allowing some employers the legal right to terminate an older worker solely on the basis of age.[6]

Senator Domenici said that compulsory retirement "hits especially hard on some women who do not start work until after the children are grown or after being widowed or divorced."

Senator Frank Church, a cosponsor of S. 481, said that the upper age limit in ADEA "may ironically have the effect of reinforcing discrimination against persons 65 years and over." He added:

> Older Americans have told the Committee on Aging time and time again [7] that inactivity is their greatest enemy. Many want to continue working to remain active. Others need to work because inflation robs their pocketbooks daily.[8]

Senator Harrison A. Williams, chairman of the Senate Committee on Human Resources, also focussed on ADEA when he introduced amendments [9] to the Age Discrimination in Employment Act of 1967:

> Their enactment will complete the statutory framework of insuring that older citizens who desire work will not be denied employment opportunities solely on the basis of age.[10]

The House effort: Representative Claude Pepper, chairman of the House Select Committee on Aging, opened a committee hearing on "Retirement Age Policies" on March 16, 1977, by describing the question of mandatory retirement as one of the most serious problems facing the elderly of this Nation today:

> This issue is filled with dilemmas and ironies. On the one hand, Congress sets individual competence—not sex, age, race, or age—as the test of employability. On the other hand, Congress refuses to protect those over 65 from age discrimination. Yet, ironically, Members of Congress insist that they be judged by performance, not age; consequently, this 76-year-old chairman of the House Committee on Aging was reelected to Congress by many persons who themselves face forced retirement at 65 years of age.

The House committee hearings [11] helped make the case for approval

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[6] Page S. 1573, *Congressional Record*, Jan. 28, 1977.

[7] Their personal observations were supported by expert opinion. Cardiologist Paul Dudley White told the committee in 1966 that continuing work opportunities would "take care of at least half of all the difficulties of old age . . . and these include medical, psychological, social, and economic problems." (P. 83, hearing on "Detection and Prevention of Chronic Disease", Sept. 21, 1966). Dr. Edward L. Bortz of Lankenau Hospital, Philadelphia, told of studies of 300 cases at that hospital which demonstrated physical problems accompanying withdrawal from action. He added: "When a man retires from life, life retires from him." (P. 116, hearing on "Retirement and the Individual," June 7, 1967).

[8] Page S. 1573, *Congressional Record*, Jan. 28, 1977.

[9] S. 1784, introduced on June 28, 1977, by Senator Williams, would have raised the age limit for ADEA to 70 in three stages and would have authorized a study of the effects of complete removal of the limit.

[10] Page S. 11108, *Congressional Record*, June 29, 1977.

[11] "Retirement Age Policies" on Mar. 16 and 17 in Washington, D.C., "Active Americans over 65 Speak on Retirement Age Policies," May 25, 1977, Washington, D.C.; "Retirement Age Policies in Massachusetts, May 6 in Brookline and Waltham, Mass.; "Active Americans Over 65: A Case Against Mandatory Retirement," July 11, 1977, New York City; "Alternatives to Retirement," May 10 and 11, June 15, July 14 and 25, 1977, in Washington, D.C.; and "Retirement Age Policies and Housing for the Elderly in Cleveland, Ohio," Aug. 8, 9, and 10, 1977.

of H.R. 5383, incorporating features of several bills, by the Employment Opportunities Subcommittee of the House Education and Labor Committee on June 29, 1977, and for approval by the full committee on July 25, 1977.

As passed by the House [12] on September 23 by a vote of 359 to 4, H.R. 5383, included the following provisions:

> The upper age limit of the act would be increased from 65 to 70 years (180 days after enactment).
>
> The Secretary of Labor would be directed to conduct a study to determine the feasibility of eliminating the upper age limit of the ADEA entirely.
>
> The age-70 limitation now applicable to Federal employees would be removed.
>
> Involuntary retirement because of age would be prohibited under a seniority system or employee benefit plan. However, any employee 65 or older but less than 70 years old could be mandatorily retired under a collectively bargained agreement until 2 years after the date of enactment or until the expiration of the existing collectively bargained agreement, whichever occurs first. The purpose of this postponement is to avoid any administrative disruption in changing existing contracts between management and labor.
>
> The $5 million authorized funding ceiling for the ADEA would be removed.

The Senate version of the Age Discrimination in Employment legislation, as passed on October 19, differed from the House bill in the following major respects:

Effective date: It would raise the upper age limit of the Age Discrimination in Employment Act to 70, effective January 1, 1979 (compared with 180 days after enactment in the House bill).

Exemptions: It would permit highly compensated employees (entitled to annual retirement benefits, exclusive of social security, of $20,000 or more) and college faculty members with unlimited tenure to be mandatorily retired at age 65 (no comparable provision in the House bill).

Federal employees: It did not include the House provision to abolish mandatory retirement completely for about 95 percent of all Federal employees.

Authorized funding: It retained the $5 million authorized funding ceiling.

Tolling statute of limitations: It would provide for tolling the statute of limitations (for up to 2 years) while the Department of Labor is engaging in conciliation activities under the ADEA (no comparable House provision).

House and Senate conferees reached final agreement on H.R. 5383 on March 2, 1978. Among the key features in the conference agreement:

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[12] Discussion of the legislation on pp. H 9967 to H 9985 in the *Congressional Record* of that date includes the following material submitted by Representative Pepper: A joint statement by 19 national organizations in support of H.R. 5383, a position statement by the Federal Council on the Aging, and statements by the National Organization for Women and the National Caucus on the Black Aged expressing opposition to mandatory retirement.

—Mandatory retirement before age 70 would be prohibited (effective January 1, 1979) for covered workers in private employment and State and local government employees.
—College and university faculty members with unlimited tenure can be mandatorily retired at age 65 until July 1, 1982, when the mandatory retirement age increases to 70 for them.
—Highly paid employees with retirement benefits of $27,000 a year or more (exclusive of social security) can be mandatorily retired at age 65.
—Mandatory retirement would be abolished for most Federal employees, effective September 30, 1978.
—The $5 million funding ceiling for the ADEA would be removed.
—The statute of limitations would be tolled for up to 1 year while the Department of Labor is engaged in conciliation activities under the ADEA.

Future Considerations

President Carter signed H.R. 5383 into law (Public Law 94–256) on April 6, 1978.

Senator Church, at a speech in Minneapolis on February 3, 1978, said that he was glad that the ADEA legislation had apparently gained "irresistible momentum." And he asked:

> But after it becomes law, what else must change?
>
> How can we help provide part-time work to those who don't want retirement all at once?
>
> How can we rearrange educational opportunities so that they extend throughout the lifetime and provide two or three careers?
>
> How can we help fight the thoughtless assumption, still deeply ingrained, that a person should be put "out to pasture" because a certain age has been reached, whether it be 65 or 70?
>
> I am fully aware that not every older American wants to work beyond age 65 or to be an active volunteer in community work.
>
> Older persons should, however, have the latitude and freedom of choice that younger persons have. As long as they can perform, they should not be denied the opportunity, solely because of age.

Senate Committee on Aging members, at a meeting on February 24, 1978, set "Retirement Policy in the United States," as a priority for committee study.

II. INCOME: THE ECONOMIC TREADMILL

Older Americans suffered through what might be called an "economic stalemate" in many respects in 1977. Some gains, to be sure, were recorded—although most were modest. But on the negative side, 1977 also produced retrogression in certain key areas.

Bureau of the Census figures released during the year confirmed earlier Committee on Aging findings that middle-aged and older Americans did not share, in many respects, to the same extent as other age groups in our Nation's recovery from the 1974–75 recession.

Nearly 900,000 persons under 65 years of age escaped from poverty between 1975 and 1976. Of this total, 774,000 were under 45 years old. In sharp contrast, only 128,000 individuals 45 or older left the poverty ranks. Among persons in the 65-plus age group, there was virtually no change at all. In 1975, 3,317,000 older Americans lived in poverty, compared with 3,313,000 in 1976.

PERSONS WITH INCOMES BELOW THE POVERTY LEVEL OR 125 PERCENT OF THE POVERTY LEVEL

[Numbers in thousands]

	1975	1976
All ages:		
Total	210,864	212,303
Poverty	25,877	24,975
Percent below poverty level	12.3	11.8
Near poor	37,182	35,509
Percent below near poverty level	17.6	16.7
Under 65 years old:		
Total	189,202	190,203
Poverty	22,560	21,662
Percent below poverty level	11.9	11.4
Near poor	31,687	29,988
Percent below near poverty level	16.7	15.8
65 years or older:		
Total	21,662	22,100
Poverty	3,317	3,313
Percent below poverty level	15.3	15.0
Near poor	5,495	5,521
Percent below near poverty level	25.4	25.0

Source: Bureau of the Census.

Nearly one out of every seven persons 65 or older is poor under the Census Bureau's 1976 definition of poverty. And one out of four older Americans would either be poor or marginally poor.

On a weighted basis, the poverty threshold is $2,720 for an aged individual, or about $52 a week. The poverty line for a couple with an aged head is $3,417, or almost $66 per week.

WEIGHTED AVERAGE THRESHOLDS—POVERTY CUTOFFS IN 1976, BY SIZE OF FAMILY AND SEX OF HEAD BY FARM-NONFARM RESIDENCE

Size of family unit	Total	Nonfarm			Farm		
		Total	Male head	Female head	Total	Male head	Female head
1 person 65 years and over	$2,720	$2,730	$2,758	$2,722	$2,322	$2,344	$2,313
2 persons head 65 years and over	3,417	3,445	3,447	3,428	2,928	2,928	2,922

Source: Bureau of the Census.

Earlier committee reports have emphasized that the low-income elderly are concentrated among women, single persons, and members of minorities.[13] These groups showed little, if any, improvement in 1977.

[13] For example, see chapter III of "Developments in Aging: 1975 and January-May 1976."

Another benchmark of income adequacy are the Department of Labor budgets for a retired couple in an urban area. In August 1977, the Department of Labor updated three hypothetical annual budgets (lower, intermediate, and higher) for retired couples to reflect changes in prices between autumn (September, October, and November) 1975 and autumn 1976.

The estimated 1976 U.S. average annual cost of the lower budget for an urban retired couple, excluding personal income taxes, amounted to $4,695. The budget costs amounted to $6,738 for the intermediate level and $10,048 for the higher level.

SUMMARY OF ANNUAL BUDGETS FOR A RETIRED COUPLE AT 3 LEVELS OF LIVING, URBAN UNITED STATES, AUTUMN 1976

Component	Lower budget	Intermediate budget	Higher budget
Total budget [1]	$4,695	$6,738	$10,048
Total family consumption	4,493	6,333	9,281
Food	1,443	1,914	2,402
Housing	1,613	2,334	3,653
Transportation	322	629	1,161
Clothing	206	347	535
Personal care	138	202	296
Medical care (preliminary estimate)	571	574	579
Other family consumption	200	332	657
Other items	202	405	767

[1] Beginning with the autumn 1973 updating of the budgets for a retired couple, the total budget is defined as the sum of "total family consumption" and "other items." Income taxes are not included in the total budgets.

Note: Because of rounding, sums of individual items may not equal totals.

The Department of Labor does not compute budgets for single persons 65 or older. However, a revised equivalent scale—based upon 28 percent of the total family consumption for an urban family with four members—would place the estimated consumption at $2,285 for the lower level, $3,464 for the intermediate level, and $4,773 for the higher level.

Census Bureau figures reveal that many older Americans have less income—and in some cases substantially less—than the intermediate budget, or what might be termed a moderate standard of living. About one out of three (35.7 percent) families with an aged head had income below the intermediate budgetary level in autumn 1976. More than 2.9 million elderly families had annual incomes below $6,738. About one out of two aged single persons had incomes below the projected intermediate consumption level for individuals 65 years or older. Almost 3.5 million older Americans living alone or with nonrelatives had income below $3,464 a year, including 1.7 million with income under $2,500.

1977 census data reveal that older Americans continue to live on substantially less income than other age groups. The median annual income for a family with an aged head amounted to $8,721 in 1976, or 58 percent of the median income level of $14,958 for all age groups. Elderly single persons had a medium income of $3,495, compared with $5,375 for all age groups.

AGE OF HEAD—FAMILIES AND UNRELATED INDIVIDUALS BY TOTAL MONEY INCOME IN 1976

[Numbers in thousands, families and unrelated individuals as of March 1977]

Total money income	Total	Age of head (years)						
		14 to 24						65 and over
		Total	18 to 24	25 to 34	35 to 44	45 to 54	55 to 64	
FAMILIES								
Total	56,710	3,964	3,932	13,180	11,221	11,170	9,035	8,141
Under $2,000	1,106	205	182	286	186	162	166	103
$2,000 to $2,999	1,086	184	182	232	139	126	146	258
$3,000 to $3,999	1,741	249	246	310	205	177	253	547
$4,000 to $4,999	1,909	194	191	358	247	182	255	672
$5,000 to $5,999	2,220	234	234	376	273	238	295	804
$6,000 to $6,999	2,216	270	270	366	335	232	326	687
$7,000 to $7,999	2,194	259	259	465	308	275	284	604
$8,000 to $8,999	2,333	283	281	541	351	280	329	550
$9,000 to $9,999	2,161	236	236	538	320	298	324	444
$10,000 to $10,999	2,355	240	240	597	402	358	367	392
$11,000 to $11,999	2,228	209	209	610	388	337	342	340
$12,000 to $12,999	2,349	207	207	709	375	386	343	330
$13,000 to $13,999	2,317	189	189	665	471	392	311	289
$14,000 to $14,999	2,232	176	176	681	446	370	318	242
$15,000 to $15,999	2,513	178	178	728	516	468	412	211
$16,000 to $16,999	2,138	140	140	618	437	368	386	189
$17,000 to $17,999	2,266	130	130	619	541	465	323	188
$18,000 to $19,999	3,907	149	149	1,146	899	858	583	272
$20,000 to $24,999	7,326	174	174	1,814	1,848	1,818	1,253	419
$25,000 to $49,999	9,013	51	51	1,449	2,247	2,999	1,754	513
$50,000 and over	1,098	5	5	74	286	382	263	87
Median income (dollars)	14,958	9,439	9,505	14,790	17,389	19,037	16,118	8,721
Standard error (dollars)	54	137	137	87	101	128	127	85
Mean income (dollars)	16,870	10,150	10,217	15,531	19,018	21,119	18,567	11,635
Standard error (dollars)	54	103	103	84	125	134	154	118
HEAD YEAR-ROUND FULL-TIME WORKER								
Percent of total excluding Armed Forces	59.7	48.7	49.0	70.4	75.0	73.2	59.5	8.8
Median income (dollars)	18,450	12,759	12,776	16,767	19,266	21,234	19,699	16,388
Standard error (dollars)	58	175	175	98	126	131	206	355
Mean income (dollars)	20,679	13,135	13,153	17,817	21,447	23,750	22,240	20,337
Standard error (dollars)	71	144	145	99	147	155	206	667
UNRELATED INDIVIDUALS								
Total	21,459	3,749	3,605	3,979	1,589	2,034	3,080	7,027
Under $1,000	1,181	485	378	145	87	156	176	132
$1,000 to $1,499	582	163	150	48	25	72	78	196
$1,500 to $1,999	904	183	176	63	39	64	146	408
$2,000 to $2,499	1,711	207	203	98	54	115	244	992
$2,500 to $2,999	1,454	163	160	96	33	70	209	883
$3,000 to $3,499	1,528	192	192	117	43	63	202	911
$3,500 to $3,999	1,033	151	151	104	46	40	137	555
$4,000 to $4,999	1,753	328	325	171	88	109	235	824
$5,000 to $5,999	1,555	315	313	219	82	151	219	569
$6,000 to $6,999	1,332	352	349	254	82	104	166	375
$7,000 to $7,999	1,177	247	247	267	91	113	186	273
$8,000 to $8,999	1,048	247	246	281	66	119	144	190
$9,000 to $9,999	913	203	203	286	61	100	137	126
$10,000 to $11,999	1,599	272	272	576	149	182	240	180
$12,000 to $14,999	1,509	150	150	561	189	204	230	175
$15,000 to $19,999	1,285	73	73	446	240	210	175	140
$20,000 to $24,999	459	8	8	154	100	86	73	38
$25,000 and over	435	8	8	93	115	76	84	60
Median income (dollars)	5,375	5,003	5,213	9,441	9,961	7,644	5,522	3,495
Standard error (dollars)	49	98	99	114	292	205	131	30
Mean income (dollars)	7,236	5,459	5,646	9,971	11,494	9,497	7,534	4,886
Standard error (dollars)	51	74	75	113	292	234	142	56
YEAR-ROUND FULL-TIME WORKER								
Percent of total excluding Armed Forces	33.7	35.6	36.9	59.7	60.1	54.2	38.8	4.0
Median income (dollars)	10,509	8,323	8,339	11,436	12,996	10,849	10,097	8,443
Standard error (dollars)	69	122	123	122	288	250	174	398
Mean income (dollars)	11,889	8,529	8,546	12,454	14,782	13,095	11,409	10,427
Standard error (dollars)	106	119	120	148	417	348	236	595

A. Jobs on Increase

The year 1977 produced several positive notes for middle-aged and older workers:

—Unemployment declined by 250,000 from December 1976 to December 1977 for persons 45 years or older.

—The number of employed middle-aged and older workers jumped by 579,000 during this same period.

—Long-term joblessness (15 weeks or longer) dropped by 134,000 from 562,000 in December 1976 to 428,000 in December 1977.

—Very long term unemployment declined from 372,000 to 266,000 in the past year.

Prior congressional efforts to provide new job opportunities for older workers plus the economic recovery (dating back to 1975) helped considerably to brighten the employment picture for mature workers.

Legislative developments in 1977 offered further encouragement for the future. One of the most potentially far-reaching actions was House and Senate approval of a bill to raise the mandatory retirement age to 70 (see pp. 21–24 for more detailed discussion).

On other fronts, the Congress increased funding for the title IX senior community service employment[14] program by 110 percent within a year—from $90.6 million to begin on July 1, 1977, to $190.4 million starting on July 1, 1978. The $99.8 million increase for title IX occurred in two stages. First, the Economic Stimulus Appropriations Act[15] boosted the funding level from $90.6 million to $150 million (the full authorized amount), available from July 1, 1977, to June 30, 1978. This action increased the number of jobs for low-income persons 55 or older from 15,000 to 37,400. Almost 80 percent of the funding is allocated to the national contractors and 20 percent to the States.

Second, a fiscal 1978 continuing resolution[16] includes $190.4 million for the title IX Older American Community Service Employment Act, effective July 1, 1978. Funding again would be allocated: 80 percent to the national contractors and 20 percent to the States. Nearly 47,000 low-income persons 55 or older will be employed under title IX beginning next July, or 213 percent greater than in June 1977.

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[14] The title IX program, which is administered by the Department of Labor, provides community service employment in a wide range of activities for low-income persons 55 or older.

[15] Public Law 95–29, approved on May 13, 1977.

[16] Public Law 95–205, approved on Dec. 9, 1977.

FUNDING AND POSITIONS FOR THE TITLE IX SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

	July 1, 1976 to June 30, 1977	July 1, 1977 to June 30, 1978	July 1, 1978 to June 30, 1979
Funding (in millions of dollars)	55.9	150	190.4
Positions	15,000	37,400	47,000

Source: Department of Labor.

The Economic Stimulus Appropriations Act also continued 71 older worker projects funded by the Administration on Aging under the title X job opportunities program of the Public Works and Economic Development Act. The Department of Labor became directly responsible for administering the title X older worker projects on November 1, 1977. The Department plans to use $15.7 million from title I discretionary funds of the Comprehensive Employment and Training Act (CETA) to continue the program from November 1, 1977, to June 30, 1978. Approximately 2,600 title X employees will be transferred to the title IX senior community service employment program on July 1, 1978. The remaining 2,700 title X employees will be maintained with $3 million in discretionary funds from the CETA title I program from July 1, 1978, through September 30, 1978.

These actions and other developments have helped to increase new enrollment for persons 45 or older in Department of Labor manpower programs from 7 percent in fiscal year 1976 (rounded to the nearest percent) to 10 percent in fiscal year 1977. This figure, though, is considerably below the middle-aged and older workers proportion (19 percent in December 1977) of the total unemployment in the United States.

FISCAL YEAR 1977 (NEW ENROLLMENTS)—DEPARTMENT OF LABOR MANPOWER PROGRAMS

Program	Total enrollment	Under 22 years old	Percent	22 to 44 years old	Percent	45 to 54 years old	Percent	55 to 64 years old	Percent	65-plus years old	Percent
Comprehensive Employment and Training Act	1,108,500	559,200	50.5	463,900	41.8	50,100	4.5	24,600	2.2	10,700	1.0
Training—title I public service employment—title II	313,700	62,600	20.0	202,100	64.4	30,200	9.6	15,800	5.0	3,000	1.0
Public service employment—title VI	371,400	71,300	19.2	240,900	64.8	36,700	9.9	18,800	5.1	3,700	1.0
Senior community service employment	17,392							8,174	47.0	9,218	53.0
Job Corps	41,200	41,200	100.0								
Summer youth	820,500	820,500	100.0								
Work incentive program	2,264,800	351,500		1,624,400		[1] 288,900		(1)		(1)	
Total	4,937,492	1,906,300	38.6	2,531,300	51.3						
Total enrollments, 45 years or older						499,892					
Percent						10.1					

[1] Figure represent participants 45 years or older. Information is not available for the age categories 45 to 54, 55 to 64, and 65-plus.

Source: Department of Labor.

B. Difficulties Remain

Despite these encouraging developments, it is still clear that middle-aged and older workers face formidable employment barriers. They run a substantially greater risk of being without a job for a long period of time after becoming unemployed. As of December 1977, an unemployed person 45 years or older could expect to be jobless 35 percent longer than for similarly situated younger individuals. The average duration of unemployment for middle-aged and older workers is more than 19 weeks, or nearly 5 months.

AVERAGE DURATION OF UNEMPLOYMENT—WEEKS

	December 1976	December 1977
All workers	15.6	15.0
Workers under 45 years old	12.8	14.4
Workers 45 years or older	20.3	19.4
Workers 45 years to 54 years old	19.1	19.3
Workers 55 years to 64 years old	20.9	18.5
Workers 65 years or older	26.7	22.2

Source: Department of Labor.

As mentioned previously, more persons 45 or older are working than a year ago. However, the overall trend during the past 10 years is, for the most part, downward. In 1967 the labor force participation rate for individuals 45 years or older was 52 percent. Ten years later, it fell to 48 percent. Among individuals aged 55 to 64, the decline was even more pronounced—from 62 percent to 57 percent.

LABOR FORCE PARTICIPATION RATE

[In percent]

Age	1967	1970	December 1977
25 to 44	70.0	71.3	77.8
45 plus	52.2	52.2	48.0
45 to 54	72.7	73.5	73.8
55 to 64	62.3	61.8	57.1
65 plus	17.2	16.9	13.4

Source: Department of Labor.

C. Employment Opportunities for Older Workers

Recently, Senators Lawton Chiles and Pete Domenici introduced legislation to amend the CETA Act. In his testimony before the Employment, Poverty, and Migratory Labor Subcommittee of the Human Resources Committee, Senator Domenici said:

> One of the most persistent criticisms of the CETA program has been its failure to provide additional job opportunities for older workers. As the number of older Americans steadily increases, the Congress will have to make a special effort to see that Federal programs are responsive to their needs. Statistics would indicate that, to date, only about 2 percent of all CETA participants are older workers. As a partial remedy to this problem, Congress enacted title IX of the Older

Americans Act. The title IX public service employment program currently provides approximately 40,000 part-time jobs for low-income older persons. When I introduced S. 2609, the 1978 amendments to the Older Americans Act, I expanded the title IX purposes to include the private sector. The Chiles-Domenici CETA amendments create a new program for older workers which will be in addition to the Older Americans Act program which is administered by national contractors. The new program will be for structurally unemployed older workers, and will include training, retraining, placement, supportive services and part-time employment. This program will be administered by prime sponsors who have, at their disposal, resources far beyond those presently available under title IX.

By providing an older workers program which is geared to the needs of this large and growing segment of the population, we address what is becoming a major economic problem in this country. It is critical that we provide suitable work modes for an aging work force. Experiments in work sharing and flextime are necessary. The creation of more part-time employment in both the public and private sectors is consistent with the needs of the labor force and an older population of workers. I urge the committee to provide an older workers strategy in CETA.

Our bill provides a separate authorization for the older workers employment programs because we recognize that there are intense local pressures on the CETA program to focus their resources on the problems of youth unemployment. By providing earmarked funds for this program, we can insure older Americans that they will receive an appropriate level of services under the Comprehensive Employment and Training Act.

III. THE NEW WELFARE REFORM PLAN AND THE ELDERLY

In August of 1977, the President submitted his welfare reform proposal to the Congress.[17] The proposal, "program for better jobs and income" (PBJI) consists of three major provisions:

—The consolidation of the aid to families with dependent children (AFDC), supplemental security income (SSI), and food stamps into one nationwide minimum Federal cash payment for the poor.

—The creation of 1.4 million public service jobs for those able and expected to work.

—The expansion of an earned income tax credit to earnings from unsubsidized public or private sector jobs.

The program for better jobs and income (PBJI) is based on a work incentive approach intended to mitigate the "welfare stigma."

[17] The Administration's welfare proposal was introduced as H.R. 9030 in the House of Representatives and as S. 2084 in the Senate.

President Carter described the new program as one which emphasizes "the fundamental American commitment to work, strengthens the family, respects the less advantaged in our society, and makes a far more efficient use of our hard-earned tax dollars." [18]

A. Jobs and the Elderly

The PBJI recognizes two groups: those not expected to work and those expected to work. Those not expected to work are the blind, disabled, elderly, and parents of children under age 7. The placement of persons 65 and over in the upper tier of those not expected to work—the income support tier—guarantees them the maximum cash assistance level of payment, $2,500 for an individual over 65 and $3,750 for a couple.[19] But this would disqualify them for the 1.4 million public service jobs created by the PBJI. Those expected to work—the earned income supplement tier—include two-parent families with children and single-parent families whose youngest child is 14 and over. Those expected to work will receive an annual guarantee of at least $2,300 with a reduction of 50 cents for each dollar of earnings exceeding $3,800.

A study prepared for the Joint Economic Committee explains:

> A social consensus seems to exist on allowing the aged, the disabled, children who are in elementary or secondary school, and mothers of the latter in two-parent households not to work.[20]

If, however, a person 65 and over chooses to work in a job other than PBJI, cash benefits will be reduced by 50 cents for every dollar of earnings.

Those persons under 65 years of age who qualify for a PBJI job must first seek employment within the private sector before qualifying for a PBJI slot. If, after an 8-week period of job search, the applicant is unable to secure employment, the jobs program will attempt to place him or her in one of the public service job or training slots. During the 8-week job search, the applicant will be eligible for cash assistance of $2,300 (for a family of four). If after the job search no placement is made, the applicant will be moved up to the upper tier—those not expected to work—and will receive a cash benefit of $4,200 (for a family of four) and again would be moved to the lower tier when and if a job placement is made.

The emphasis of the jobs program on families with children, together with the question of whether enough jobs will be created to meet the demand, appears to lessen the PBJI's potential effectiveness for the older worker. Persons between the ages of 50 and 64, who traditionally have more difficulties in securing employment, will thus be faced with

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[18] Message to the Congress of the United States from the President on the program for better jobs and income, Aug. 6, 1977.

[19] For detailed description of cash assistance, see section B of this part.

[20] "Work, Welfare, and the Program for Better Jobs and Income," a study prepared for the use of the Joint Economic Committee, Congress of the United States, by Professors Leonard J. Hausman and Barry L. Friedman of Brandeis University, Oct. 14, 1977.

similar difficulties in the Government's proposed program for better jobs.[21]

B. PBJI Cash Assistance as Compared to SSI

The number of persons receiving supplemental security income (SSI) during 1977 numbered approximately 4.2 million, according to the Social Security Administration. Aged recipients accounted for about 2.1 million, disabled persons for 2 million, and blind persons for about 76,000. Approximately $5 billion in Federal benefits and $1.5 billion in State supplementary payments were made. Aged recipients received an average Federal payment of $78.75 and an average State supplement of $68.12. However, the total average benefit is $92.92 because not all States offer the SSI supplement.

Other statistics:

—28.7 percent of the 2.1 million aged recipients were men;

—71.2 percent were women;

—black recipients numbered approximately 24.4 percent; white recipients were 65.2 percent; and "others" were 2.9 percent;

—88.1 percent of the aged recipients lived in their own households; 7.5 percent lived in households of another; and 4.4 percent lived in institutions covered by medicaid;

—70 percent of the aged recipients also received social security benefits; 12.2 percent received other unearned income (pensions, railroad retirement, veterans benefits, etc.); and 2.4 percent had earned income.[22]

The number of persons receiving SSI by State and by classification were:

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[21] On Feb. 8, 1978, the House Welfare Reform Subcommittee completed work on H.R. 9030, Program for Better Jobs and Income, and made substantial changes in the public service employment jobs provisions. Essentially, the subcommittee replaced the full jobs section of the proposal with amendments to the Comprehensive Training and Employment Act (CETA). These provisions would create a new title IX under CETA for economically disadvantaged individuals. This new title would provide limited eligibility for job search assistance and subsidized jobs to individuals who are certified as eligible for cash assistance under the PJBI; index the subsidized CETA wage rates in order that the rates would be more responsive to the trend in local average wages; and authorize open-ended funding for the jobs component of the welfare reform bill.

An eligible individual is defined under the new subcommittee bill as one who (a) is the principal earner in a household unit which includes at least one child and which is eligible for cash assistance under the proposal; (b) participates in an 8-week job search before requesting a subsidized job; and (c) does not refuse a bona fide job offer during the period immediately preceding participation in the job search program.

The subcommittee's version of welfare reform, new bill H.R. 10950, was jointly referred to three House committees: Agriculture, Education and Labor, and Ways and Means. The Senate Finance Committee has held hearings on the administration's proposal but had not, at this writing, begun markup of the legislation.

[22] Data on SSI recipients from "Social Security Bulletin," Social Security Administration, December 1977, volume 40, No. 12.

SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED: NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, BY REASON FOR ELIGIBILITY AND STATE, JUNE 1977

State	Total	Aged	Blind	Disabled
Total [1]	4,223,742	2,095,921	76,255	2,051,566
Alabama [2]	141,409	91,133	1,898	48,378
Alaska [2]	3,081	1,291	77	1,713
Arizona [2]	28,611	13,161	466	14,983
Arkansas	84,943	52,497	1,629	30,817
California	682,536	323,076	16,716	342,744
Colorado [2]	33,371	17,337	335	15,699
Connecticut [2]	22,530	8,393	307	13,830
Delaware	6,780	2,962	216	3,602
District of Columbia	14,777	4,656	191	9,930
Florida	161,501	88,949	2,509	70,043
Georgia	159,720	84,064	2,919	72,737
Hawaii	9,476	5,223	130	4,123
Idaho [2]	8,022	3,441	100	4,481
Illinois [2]	129,143	42,286	1,596	85,261
Indiana [2]	41,046	18,953	1,028	21,065
Iowa	27,283	13,940	1,102	12,241
Kansas	22,653	10,709	336	11,608
Kentucky [2]	96,633	51,828	1,999	42,806
Louisiana	148,492	83,009	2,145	63,338
Maine	23,091	11,887	268	10,936
Maryland	47,761	17,879	539	29,343
Massachusetts	130,448	76,490	4,470	49,488
Michigan	116,788	45,810	1,607	69,371
Minnesota [2]	35,861	16,366	658	18,837
Mississippi	119,388	73,403	1,868	44,117
Missouri [2]	93,606	53,948	1,716	37,942
Montana	7,700	3,105	142	4,453
Nebraska [2]	14,510	7,163	231	7,116
Nevada	5,850	3,418	321	2,111
New Hampshire [2]	5,365	2,672	139	2,554
New Jersey	79,736	34,864	993	43,879
New Mexico [2]	25,952	11,682	416	13,854
New York	384,558	158,672	3,989	221,897
North Carolina [2]	144,963	73,285	3,485	68,193
North Dakota [2]	7,351	4,193	66	3,092
Ohio	125,263	45,728	2,360	77,175
Oklahoma [2]	78,441	44,926	1,053	32,462
Oregon [2]	23,911	9,117	539	14,255
Pennsylvania	163,067	65,761	3,990	93,316
Rhode Island	15,675	6,635	184	8,856
South Carolina [2]	82,085	43,210	1,882	36,993
South Dakota	85,551	4,799	121	3,631
Tennessee	134,140	72,062	1,756	60,322
Texas [3]	272,125	173,025	3,976	95,124
Utah [2]	8,450	3,058	159	5,233
Vermont	8,653	4,114	110	4,429
Virginia [2]	78,279	40,263	1,433	36,583
Washington	48,946	18,484	507	29,955
West Virginia [2]	42,436	17,684	636	24,116
Wisconsin	66,407	34,165	911	31,331
Wyoming [2]	2,228	1,094	31	1,103
Unknown	150	50	----------	100

[1] Includes persons with Federal SSI payments and/or federally administered State supplementation, unless otherwise indicated.
[2] Data for Federal SSI payments only; State has State-administered supplementation.
[3] Data for Federal SSI payments only; State supplementary payments not made.

As reported last year, the SSI payments failed in most States to bring the recipients above the poverty threshold.[23] For an individual, the SSI Federal minimum guarantee level is $2,134 while the poverty threshold for an aged individual is $2,720. SSI provides a Federal minimum payment of $3,200 to a couple while the poverty threshold for the same elderly couple is $3,417. Even in many of the 39 States which supplement the Federal payment, the levels, as shown in the following tables, are below the poverty threshold.

[23] See "Developments in Aging, 1976," chapter I, "What Next Steps on Income."

SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED: AVERAGE MONTHLY AMOUNT OF STATE-ADMINISTERED STATE SUPPLEMENTATION, BY REASON FOR ELIGIBILITY AND STATE, JUNE 1977

State	All persons				Persons with Federal SSI and State supplementation				Persons with State supplementation only			
	Total	Aged	Blind	Disabled	Total	Aged	Blind	Disabled	Total	Aged	Blind	Disabled
Alabama	$52.30	$48.82	$47.42	$70.23	$50.29	$47.13	$42.38	$70.25	$58.67	$54.93	$61.61	$70.20
Alaska	115.33	106.24	119.14	123.45	121.75	111.74	121.56	130.71	82.02	79.54	103.78	83.66
Arizona	82.58	86.48	[1]	31.47	73.63	78.32	[1]	29.93	105.57	105.47	----------	[1]
Colorado	48.51	41.07	55.13	63.72	37.62	35.11	49.56	42.40	82.55	58.74	96.19	137.74
Connecticut	78.81	70.98	57.00	83.39	66.71	67.25	52.71	66.64	90.03	75.11	63.49	97.39
Florida	50.87	47.26	48.05	53.53	50.87	47.26	48.05	53.53	[2]	[2]	[2]	[2]
Idaho	62.91	53.55	----------	71.01	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Illinois	68.15	53.73	56.96	71.38	47.82	43.28	52.30	48.76	121.77	85.08	85.15	128.96
Kentucky	99.83	97.52	72.77	104.80	99.85	96.54	70.88	105.82	99.75	101.24	93.00	93.22
Maryland	110.20	99.04	[1]	118.75	[4]	[4]	[4]	[4]	110.20	99.04	[1]	118.75
Minnesota	69.03	63.75	67.11	73.25	66.26	59.86	65.89	71.09	87.98	85.95	74.94	90.77
Missouri [5]	33.46	30.27	95.38	37.83	29.76	27.78	76.32	32.02	44.56	38.35	136.09	50.08
Nebraska	51.07	39.41	58.68	60.43	50.38	39.22	55.82	58.96	53.94	40.10	73.74	67.89
New Hampshire	62.03	37.48	60.28	84.17	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
New Mexico	[6] 29.62	[1]	----------	[1]	[6] 30.00	[3]	----------	[3]	[1]	[1]	[1]	[1]
North Carolina	154.82	154.70	176.84	153.50	163.05	163.23	164.30	162.77	119.33	118.03	193.66	108.86
North Dakota [7]	20.57	19.80	[1]	22.09	20.50	19.60	[1]	22.22	[1]	[1]	[1]	[1]
Ohio	445.32	----------	----------	445.32	135.77	----------	----------	135.77	582.46	----------	----------	582.45
Oklahoma	32.02	32.22	31.20	31.64	32.22	32.38	31.23	31.92	27.94	28.80	[1]	26.21
Oregon	28.44	29.38	46.26	26.57	29.81	33.01	47.50	27.06	21.17	18.75	39.81	22.55
South Carolina	[6] 73.06	72.33	72.50	75.32	[3] 73.06	72.33	72.50	75.32	[2]	[2]	[2]	[2]
South Dakota	94.83	97.91	----------	88.38	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Virginia	57.52	57.10	52.70	58.34	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[4]
West Virginia [3]												

[1] Not computed on base of less than $500.
[2] No persons receiving State supplementation only.
[3] Data not available.
[4] No persons receiving SSI and State supplementation.
[5] Represents data for May; data not available for June.
[6] Includes optional supplementation data for New Mexico and mandatory supplementation data for South Carolina; not distributed by reason for eligibility.
[7] Excludes data for optional supplementation; data not available.

SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED: AVERAGE MONTHLY AMOUNT OF FEDERALLY ADMINISTERED STATE SUPPLEMENTATION, BY REASON FOR ELIGIBILITY AND STATE, JUNE 1977

State	Average monthly amount			
	Total	Aged	Blind	Disabled
Total	$72.06	$68.12	$102.53	$74.38
Arkansas	14.97	15.21	14.80	14.45
California	104.42	95.20	141.01	111.52
Delaware	68.15	64.05	53.84	76.36
District of Columbia	29.92	28.37	23.69	30.61
Florida	20.99	21.59	15.97	20.92
Georgia	21.70	21.41	22.56	22.18
Hawaii	39.11	34.39	43.28	45.05
Iowa	35.86	36.26	27.20	48.56
Kansas	37.67	36.56	49.06	37.48
Louisiana	21.85	21.51	19.00	27.97
Maine	17.54	15.62	23.13	19.49
Maryland	35.77	32.90	31.38	37.90
Massachusetts	84.49	80.74	140.34	85.34
Michigan	44.22	38.92	32.85	48.10
Mississippi	10.74	10.37	8.95	12.44
Montana	92.27	61.65	175.00	95.05
Nevada	41.78	36.82	114.54	9.52
New Jersey	34.92	31.01	32.72	38.63
New York	52.62	51.28	53.07	53.56
Ohio	29.52	29.17	29.61	29.79
Pennsylvania	33.78	32.00	37.87	34.86
Rhode Island	32.48	29.56	33.32	34.73
South Dakota	28.89	25.76	25.90	32.23
Tennessee	15.63	14.39	32.75	16.17
Vermont	38.55	37.17	37.27	39.90
Washington	27.10	24.45	29.07	28.89
Wisconsin	71.14	62.43	79.17	81.61

The performance of SSI in bringing more blind, disabled, and elderly persons out of poverty—as compared with the former programs of aid to the blind, aid to the permanently and totally disabled, and old-age assistance—is under continuing scrutiny. The Social Security Administration's survey of the low-income aged and disabled (SLIAD) is based on four national samples, selected in 1973, of 18,000 noninstitutionalized persons. Preliminary SLIAD findings reveal that SSI did indeed help lift some of the poorest individuals to a level of greater income. However, those individuals in the States providing greater supplementation have not shared in such an increase. In some instances, individuals experienced a decrease or no improvements in their benefits.[24]

An example of the deterioration or stabilization of SSI payments was reflected in a description of the situation in New York:

> Even taking into account the CPI pegged increases in both OASI and SSI, and the timely assent of the State legislature in passing through such increases, the SSI payment cannot catch up so to speak, because of the inflationary pressures. The CPI in New York City has increased 7.4 percent from 1974–75 and 6.5 percent from 1975–76. The percent increase of SSI averaged 5.7 percent and 4.6 percent for these same periods. Thus buying power for these very people decreased about 3.6 percent during this period.[25]

[24] For a detailed summary of the SLIAD, see "Social Security Bulletin," February 1978, Volume 41 No. 2, "First Year Impact of SSI on Economic Status of 1973 Adult Assistance Populations."

[25] "SSI: An Adequate Income for the Elderly?", presented by Community Service Society of New York and Human Resources Administration of New York City at the Gerontological Society Thirtieth Annual Meeting, November 1977.

The SSI program's original benefit levels were set at levels below the poverty level in the expectation that such levels would be supplemented by States. But these State supplements often fluctuate.

According to one researcher:

> Experience with the first Federal SSI cost-of-living raise showed that the States were indeed willing to decrease their supplementation but at the expense of a raise in beneficiaries' benefits need to keep pace with inflation. When a 6.4 percent increase was approved, some 37 States decreased their supplementation by a similar amount.[26]

Similar concerns are now being expressed about the cash assistance provision of the administration's welfare proposal, PBJI.

As mentioned previously, SSI would be absorbed into PBJI, along with aid to families of dependent children (AFDC) and the food stamp program. The cash assistance payments made under PBJI would be based on the income of the "household unit." For persons 65 years of age and older, a household unit would be defined as an elderly person living alone or with a nonrelative, an elderly person and a spouse, and an elderly person, spouse and their children. This definition of a household unit allows the elderly person to file separately for the benefits even if they are sharing a house with other relatives.

Comparisons between the SSI benefit for the elderly and cash assistance under PBJI are difficult. The answers cannot be generalized as the benefits will vary according to individuals and the degree of State supplementation. A Joint Economic Committee study goes as far as to state that many will suffer a decline in benefits under PBJI unless the decline is offset by State supplementation.[27]

The Congressional Budget Office estimates that approximately 8 percent of elderly households would lose benefits under the PBJI, 21 percent would gain and about 70 percent would retain relatively the same payments. These estimates are based on the following comparisons between the SSI program and the PBJI proposal:

Eligibility:

SSI: On the individual and his/her place of residence.

PBJI: On the household unit.

Level of assistance:

SSI: Individuals, $2,133.60 yearly (indexed with cost of living); food stamp bonus, $300–$480 yearly. Couples, $3,200 yearly (indexed with cost of living); food stamp bonus, $500–$660 yearly.

PBJI: Individuals, $2,500 yearly (not indexed with cost of living, food stamp bonus consolidated in maximum benefit). Couples, $3,750 yearly (not indexed with cost of living, food stamp bonus consolidated in maximum benefit).

Countable income:

SSI: income is counted upon a prospective 3-month period.

PBJI: income is counted retrospectively over previous 6 months.

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[26] "SSI As Welfare Reform: Some Cautionary Notes," by Elizabeth Meyer, The Journal, The Institute for Socioeconomic Studies, spring 1976.

[27] Source as cited in footnote 20.

Disregard of earnings:

SSI: Disregard of first $780 in annual earned income and one-half of the remainder over $780.

PBJI: Disregard of half (50 cents of every $1) of all earned income.

Disregard or counting of unearned income:

SSI: Disregard of first $20 of unearned income (social security, pensions, regular contributions from relatives, etc.) and after that a $1 reduction for each additional $1 of unearned income.

PBJI: Counts 100 percent of assistance income (veterans pensions) and counts 80 percent of nonemployment assistance (social security, railroad retirement, dividends and interests, etc.).

Assets limitations:

SSI: Individual is allowed $1,500 in assets and a couple is allowed $2,500 (excluding home, household goods, car, and personal effects of reasonable value).

PBJI: Household unit is allowed $5,000 of nonbusiness assets. However, 1.25 percent of nonbusiness over $500 assets are assumed as income (excluding the owner occupied home, car, and reasonable amounts for burial savings and personal effects).

"Living in household of another":

SSI: Recipients benefits is reduced by one-third if individual lives in household of another and does not pay a reasonable amount for room and board.

PBJI: Would not reduce benefit at all if individual lives in household of a nonrelative but would reduce benefit by a flat $800 if individual lives in household of relative and did not have ownership and by $400 if the individual claimed ownership.

State supplementation:

SSI: Mandatory supplementation for States to maintain 1973 income levels for assistance recipients and optional supplementation for States to provide general supplements to Federal payments.

PBJI: No mandatory supplementation but provides an incentive for States to supplement by allowing a 75 percent Federal match of first $500 of each State supplement and a 25 percent match of further supplements until the sum of the household's payments reach the poverty level (States will be under a "hold harmless formula" for current welfare beneficiaries, meaning that States cannot decrease their benefits below current levels).

FINDINGS AND RECOMMENDATIONS

Prior legislative actions and an overall improvement in the economic picture have helped to improve the economic well-being of persons aged 45 to 64. However, individuals 65 or older continue to remain on an economic treadmill. The number of persons 65 or older living in poverty remained virtually unchanged from 1975 to 1976.

The committee recommends several actions to improve the income and employment position of aged and aging Americans:

—Legislation to extend the Older Americans Act should include authority to continue and expand the title IX senior community service employment program.
—Any welfare reform legislation affecting older Americans should establish a level of income adequacy eventually abolishing poverty for the elderly.
—The Department of Labor should take action to provide meaningful and fulfilling jobs for the title X older workers who cannot be transferred to the title IX senior service corps.
—The Department of Labor should encourage local units of government and other prime sponsors to assure that middle-aged and older workers are appropriately represented in CETA work and training programs.
—A program should be established within the Comprehensive Employment and Training Act to address the problems of older workers, including provisions to attack unemployment through training, job development, supportive services, and public service employment.
—Retired senior volunteers should be used to provide employment referral and other assistance to middle-aged and older workers in areas where there is large scale unemployment because of a plant shutdown or other major reduction in the work force.
—The title IX program should be made more flexible by extending eligibility to persons with incomes above the poverty lines.

CHAPTER III

THE HIGH COST OF ENERGY

Unusually severe winter weather, increasingly high fuel prices, and legislation offered by President Carter to establish a national energy plan combined, in 1977, to sharpen congressional attention to energy-related issues.

Three hearings held by the Special Committee on Aging on "The Impact of Rising Energy Costs on Older Americans" yielded new information leading to legislative initiatives which promise to improve the Department of Energy's weatherization program for low-income Americans, and helped win Senate approval of a special refundable tax credit for low and moderate income elderly. However, despite their approval by the Senate, these measures continue to await final congressional resolution of the natural gas and tax portions of the energy plan before being enacted.

The Congress also approved an additional $200 million for crisis intervention during energy emergencies, despite some questions about the implementation of this program by the Community Services Administration and assisted communities.

Information initially requested by this committee alerted the public to the severe effects of accidental hypothermia on the elderly; and the Federal Trade Commission launched an investigation of the insulation industry as consumer complaints about inadequate and unsafe materials became more widespread. And several States took action to initiate utility rate structures and practices intended to provide more equitable treatment to low-income residential consumers.

I. COMMITTEE ON AGING HEARINGS[1]

In his opening remarks, Committee Chairman Frank Church noted that the purpose of the hearings was to fulfill the committee's responsibility to obtain information which could be considered by the Congress as it evaluated the President's energy proposals.

Senator Church continued:

> That message, it is clear, will have to deal with many "big picture" issues, including long-term plans for development or rechanneling our energy sources, changing national fuel conservation habits, and so on. But it should also include a plan to make certain that the elderly and other persons who suffered during last winter's cold will be more directly and promptly helped when the cold winds blow again.[2]

[1] "The Impact of Rising Energy Costs on Older Americans," hearings before the Senate Special Committee on Aging, Washington, D.C.; part 4, Apr. 5, 1977; part 5, Apr. 7, 1977; part 6, June 28, 1977.

[2] Hearings noted in footnote 1, part 4, p. 236.

The information developed in these hearings revealed the depth of the distress among the elderly and the lack of an adequate strategy of government assistance. Major points made in the testimony included:

(1) Rising energy prices were having a devastating impact upon many older Americans.

During 1976, depending on their region, low-income elderly had spent between 16 and 27 percent of their disposable income on energy for their homes. Turning his attention to the acute seasonal impact which energy costs could place upon the poorest older Americans, Federal Energy Administrator (FEA) John O'Leary testified, as to the first quarter of 1977:

> It is probably realistic to assume that at least some . . . were spending up to 50 percent of their disposable income on their fuel bills or perhaps not paying them during that period of time.[3]

Testimony from other witnesses showed that, during the winter of 1976–77, home heating bills of $100 to $300 monthly, and the threat of termination for nonpayment, were not uncommon for older homeowners in the more severely affected parts of the Nation.

Rising fuel bills placed a particularly disproportionate burden on those elderly least able to bear it. Older Americans with annual incomes of less than $5,000 were projected by the FEA to spend a higher percentage of disposable income for household energy than those in more confortable brackets. This difference was particularly pronounced in the Northeastern States, where elderly in this income class were estimated to have expended 27.3 percent of their income on energy in 1976. (See chart 1.) Further, because these elderly utilized energy almost exclusively for necessities, had turned down thermostats to a level which could threaten their health, and lacked the economic resources to undertake extensive insulation, their demand for energy was the least elastic for any of the income groups.

(2) Energy prices were rising at a much faster pace that the Consumer Price Index (CPI) and, consequently, were outdistancing social security cost-of-living increases.

Between the Arab oil embargo in 1973 and the spring 1977 Committee on Aging hearings, energy costs had increased in a range from 46 percent for electricity to a staggering 108 percent for home heating oil. However, the CPI had gone up only 31 percent during this period. Social security payments had risen 28 percent. Energy costs were becoming an ever-growing portion of retirees' budgets; the most severe rise was registered in the North Central States, where low-income elderly faced fuel bills 68 percent higher than they had been 3 years earlier. The more than 2.3 million older Americans receiving minimum supplemental security income (SSI) benefits in 1976 ($168 monthly at that time for individuals, $252 for couples) were faced with fuel increases which, added to jumps in costs for food, health care, and other necessities, placed them in peril.

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[3] Hearings noted in footnote 1, part 5, p. 314. A concrete example of the combined impact of rising housing and energy costs was provided in a report, "The Status of Older New Yorkers," by the New York City Department for the Aging in August 1977. It said: "Increases in costs of housing, fuel, and utilities have far outpaced increases in income of the elderly. Homeownership, which many assume to be a sign of well-being, brings its special cost burdens for the elderly. Although only a thrid of the city's elderly are homeowners, this group has faced rises of 110 percent for fuel oil; 60 percent for gas; 59 percent for electricity. Except for those who qualify for rent increase exemptions or for tax abatement, there is no way to offset the burden of increased housing costs except by cutting back on other basic expenditures: in other words, reducing one's standard of living."

CHART 1

Average Annual Cost of Home Fuels and Percent of Income Spent on Fuel, Age 60 and Over, 1973 and 1976 (by disposable income and region)

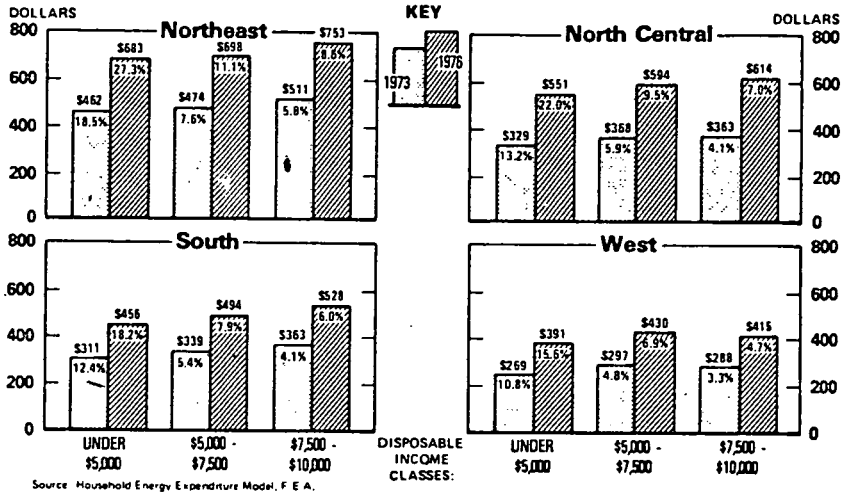

Chart 1 displays in graphic form information developed by the Federal Energy Administration for the Special Committee on Aging on this impact for different income groups of older Americans in the Nation's various regions.

(3) During the 1976–77 winter, the Government's emergency assistance program failed to reach and meet the needs of too many elderly in need.

The Community Services Administration (CSA), faced with demands for assistance which overtaxed its small staff and funding, was unable to lend aid to more than a small fraction of low-income elderly households. Still other elderly were never apprised of the availability of help because of inadequate resources for community outreach. The Congress responded to the crisis by earmarking $200 million in a supplemental appropriations bill [5] for assisting impoverished Americans in paying their fuel bills. However, the need to develop administrative regulations and a disbursement mechanism prevented funds from reaching the States and providing relief until August 1977.

(4) The Federal effort to assist older Americans in insulating their homes had been diffuse and inadequate to meet this vital need.

At least four Federal agencies—CSA, FEA, the Department of Housing and Urban Development (HUD), and the Farmer's Home Administration (FmHA)—were authorized to weatherize the residences of low-income elderly. Further, some of these programs depended for manpower on the Labor Department-run Comprehensive Employment and Training Act (CETA) and on workers paid under title IX (community service employment) of the Older Americans Act.

[5] Public Law 95-26, enacted May 4, 1977.

Looking at the evidence of overlapping efforts and seeking results, Ranking Minority Member Pete Domenici asked:

> When we are talking about making grants to poor people, be they old or otherwise, is there any reason why we should not have one national weatherization program doing that with consistent regulations and administered by a single agency, nationally?[6]

CSA, administering the largest of the four programs, had weatherized in the 1974–77 period less than 3 percent of the 5.3 million households occupied by those persons who, because their income was not more than 125 percent of the poverty level, were eligible for such assistance.

(5) Current utility rates were inappropriate and inequitable.

Utility pricing structures were found to discourage conservation because of declining block-rates which made each additional energy unit cost less. Small residential users generally paid the highest average rate.

(6) Elderly homeowners were unable to utilize their greatest financial resource—the equity of their homes—for insulation and other maintenance efforts.

The regular refinancing market (second mortgages) was closed to older homeowners, often solely on the basis of their age. Thus cut off from the resources required to upgrade their dwellings, elderly homeowners were confronted by high fuel bills as their homes declined in value and marketability.

Mr. G. H. Wang, the retired director of the city of Chicago's Housing and Energy Conservation Services, urged the committee to "give serious consideration and study on how to help the elderly to get the equity out of their homes."[7] He proposed that lending institutions be permitted to issue "reverse mortgages" which could pay annuities to retirees and then be repaid by their estates; and that the Government explore innovative arrangements in which it could purchase a home, upgrade it, and then lease it back to the original owner.

(7) Escalating gasoline prices were aggravating the already severe transportation difficulties of many elderly.

Older Americans generally face transit problems because of physical infirmities and declining income. Rising gas prices further restricted their opportunities to operate private autos while, at the same time, rising insurance and maintenance costs threatened cutbacks in the special transportation programs designed to assist the elderly. (See chapter X, section XI, for additional discussion of transportation issues.)

II. CONGRESSIONAL ACTION ON ENERGY

During 1977, the Congress responded affirmatively to President Carter's call for the creation of a cabinet-level Department of Energy. It also devoted a major portion of its time to the consideration of his national energy plan. While action was not completed during the year on this complex and far-reaching proposal, Senate-House conferees

[6] Hearings cited in footnote 1, part 6, p. 436.

[7] Hearings cited in footnote 1; part 4, p. 253. See chapter VII of this report for further developments on the "reverse mortgage" concept.

did agree on a number of provisions which promise to be of significant assistance to the elderly. The Congress also appropriated a second $200 million round of crisis intervention funds for assisting the poor to pay fuel bills during the 1977–78 winter. However, questions were raised about the competency of CSA, the administering agency, and the distribution of the first round of funding during August 1977.

A. Establishment of the Department of Energy

On August 4, 1977, with praise for "unprecedented quick action by the Congress," [8] President Carter signed the legislation creating the Department of Energy (DOE) he had proposed 5 months earlier. This twelfth Cabinet department combines the prior functions of the Federal Power Commission, Federal Energy Administration, and Energy Research and Development Agency, as well as parts of other agencies. Its initial staffing totaled 20,000 employees and its budget exceeded $10 billion.

The President proposed, in his fiscal year 1979 budget, that all low-income weatherization efforts be transferred from CSA to this new Department. The requested $198.9 million would permit insulation of up to 857,000 homes for annual fuel cost savings estimated at about 15 percent by Energy Secretary Schlesinger. [9]

B. Actions on the National Energy Plan

In April 1977, President Carter submitted to the Congress a national energy plan whose major features, as described by the White House, were:

—Conservation and fuel efficiency.
—Rational pricing and production policies.
—Reasonable certainty and stability in Government policies.
—Substitution of abundant energy resources for those in short supply; and
—Development of nonconventional technologies for the future.[10]

The plan has undergone considerable congressional revision. The impetus for alteration was strengthened following the release of a Congressional Budget Office analysis which pronounced the plan as "overoptimistic," [11] and a General Accounting Office (GAO) critique which asserted that it could not meet the conservation goals set by the President. Monte Canfield, Jr., Director of GAO's Energy and Minerals Division, testified before the House Committee on Government Operations:

> Since, under the best circumstances, plans designed to meet goals often fall short, we believe that the plan approved by Congress should be designed to provide a reasonable opportunity of achieving the stated goals.[12]

Disagreements between the House and Senate positions on the natural gas and tax portions of the energy plan had delayed final action as of this writing. However, resolution had been reached on the following items of importance to older Americans:

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[8] Washington Post, Aug. 5, 1977.
[9] Congressional Record, Jan. 27, 1978, p. E223.
[10] "The National Energy Plan," Executive Office of the President for Energy Policy and Planning; Apr. 29, 1977; pp. IX–X.
[11] Washington Post, June 1, 1977, p. A1.
[12] New York Times, June 9, 1977.

UTILITY RATE REFORM

The conference agreement requires State regulatory commissions to make findings, within 3 years, on the appropriateness of time-of-day, seasonal, cost-of-service, interruptible, and other rate measures designed to spread demand on utilities and promote equity between various user classes. These commissions are also required to prohibit declining block rates unless they can provide a cost justification for this traditional rate structure.

The agreement also authorizes DOE to intervene in these rate proceedings; provides compensation for their costs to citizens who, through their participation in a regulatory proceeding, substantially contribute to the approval of rate changes; and requires the Energy Secretary to review annually State rate actions and make further recommendations to the President and the Congress. State regulatory agencies are also encouraged to adopt procedures which protect consumers against "abrupt" service termination, and to review automatic fuel adjustment clauses. Utilities would be required to provide better information to regulatory agencies to assist them with these new responsibilities.

The Conferees rejected a provision, advanced by Senator Gary Hart and adopted by the Senate, which would have mandated "lifeline rates" for the elderly.[13] Although this provision runs counter to the conference decision to leave ratemaking, for the time being, entirely within State control, the conferees agreed to reconsider this decision if the tax conferees rejected a refundable tax credit for the elderly which had been adopted by the Senate after its introduction by Senators Domenici and Church.

FUEL ADJUSTMENT CLAUSES

In addition to the State review noted above, the Federal Energy Regulatory Commission is required to conduct periodic reviews of automatic adjustment clauses for the purpose of determining whether they encourage conservation and reflect only costs susceptible to periodic fluctuations.

In July 1977, the Senate Committee on Governmental Affairs released new information showing that, during 1976, utility customers paid $3.1 billion more for electric and natural gas than in 1975 because of formal regulatory rate increases, but $9.6 billion more from fuel adjustment clauses. Senators Edmund Muskie and Lee Metcalf wrote:

> It thus appears that the FAC's are being used by utilities, with commission sanction, to throw a blanket over more and more of the utility costs which should be openly reviewed and subjected to challenge. . . . Abuse of fuel adjustment clauses suggests that the public might be better served by

[13] The lifeline concept would guarantee a subsistence level of energy to residential consumers for the lowest rate charged by the utility to any customer. However, some analysts have asserted that the lifeline rate, besides being an incorrect and inefficient means of redistributing income, would sometimes actually hurt the low-income individuals it was designed to help (e.g., elderly persons residing in large, underinsulated private homes or in master-metered apartments whose landlords are charged commercial utility rates). See "Electric Utility Rate Reform," CRS Multilith 77-43 S, Feb. 14, 1977, pp. 21-22; and "Electric Utility Lifeline Rates: Concepts and Practices," CRS Multilith 77-229 E, Oct. 19, 1977. Senator Edward Kennedy, at pp. S1986-88 of the Congressional Record of Feb. 21, 1978, had printed the testimony of MIT Economist Lester Thurow before the Joint Economic Committee on "Energy Costs and the Poor." Professor Thurow asserted that refundable tax credits would be a more efficient means of alleviating the price burden than lifeline rates.

their abolition and reliance on traditional ratemaking procedures.[14]

AID TO THE STATES

Conferees authorized, through fiscal year 1980, $40 million for grants to State public utility commissions to carry out their new responsibilities, $25 million for the operation of State offices of consumer services, and $23 million for the funding of innovative State rate structure initiatives. In addition, an office was established within FERC for the coordination of assistance to public intervenors who substantially contribute to FERC deliberations.

RESIDENTIAL CONSERVATION

The conferees established a major role for utilities in assisting residential customers to insulate their homes. Large utilities would be required to send information to their customers regarding conservation, including lists of local insulation suppliers and financial institutions willing to make conservation loans. At customer request, utilities would have to inspect homes to advise on weatherization measures; the utility could also arrange for the installation and financing of insulation in residential dwellings, by other institutions. However, the loan and installation fees could be repaid by the customer as part of his utility bill. The bill also directs the Federal Trade Commission to study, and report to Congress within 18 months, whether utilities should be permitted to provide installation and financing directly. In the interim, utilities would be permitted to make conservation loans of up to $300 and to install devices to improve furnace efficiency and take advantage of off-peak discount rates.

C. Weatherization Amendment

For low-income Americans, the conferees adopted a Senate amendment introduced by Senator Frank Church.[15] The Church amendment would:

—Extend FEA weatherization assistance to the near poor by raising the eligibility limit from 100 to 125 percent of poverty level.
—Raise the material cost limit for assisted dwellings from $400 to $800, to permit adequate upgrading for homes requiring extensive weatherization.
—Establish consistent rules for eligibility, grant limits, permissible activities, and weatherization standards for both the CSA and DOE low-income assistance programs.
—Require consultation between DOE and CSA in developing programs and regulations.
—Make title IX Older American Community Service workers eligible for employment in these weatherization efforts.
—Authorize $25 million for insulating HUD-assisted housing, including section 202 projects for the elderly, experiencing financial hardship because of energy costs.

[14] "Electric and Gas Utility Rate and Fuel Adjustment Clause Increases, 1976," prepared for the Subcommittee on Intergovernmental Relations and the Subcommittee on Reports, Accounting, and Management of the Senate Committee on Governmental Affairs by the Economics Division, Congressional Research Service, July 1977, p. VII. For additional discussion of FAC's, see pp. 151–152, "Developments in Aging: 1976," U.S. Senate Special Committee on Aging.

[15] See Congressional Record, Sept. 9, 1977, pp. S14557–59 for Senate debate and agreement to this amendment.

During 1977, the DOE weatherization program disbursed $27 million for the upgrading of approximately 115,000 homes; about 80 to 85 percent of these were occupied by elderly individuals. (The Community Services Administration expended $82.5 million on low-income weatherization activities in fiscal year 1977.) As noted, President Carter wishes to transfer all such activity to DOE and has proposed funding levels of $130 million in fiscal year 1978 and about $200 million in each of fiscal years 1979 and 1980.

D. Other Actions

In addition to these actions, conferees also approved a loan program for all homeowners wishing to install solar heating, hot water, cooling equipment, and a subsidized low-interest loan program for conservation measures undertaken by families whose incomes fall below the median for their area of residence.

NATURAL GAS PRICING

The issue of natural gas deregulation, which has been debated since the 1954 Supreme Court ruling that gas piped across State lines was subject to regulation, produced a deadlock of Senate and House conferees for 3 months. However, on March 3, 1978, Senator Henry Jackson announced that a majority of Senate conferees had reached agreement on a formula which should be acceptable to the House and permit the Congress to complete its work on the National Energy Plan. That agreement would:[16]

—Raise the price ceiling on newly discovered natural gas from the current regulated level of $1.48 per thousand cubic feet (M ft^3) to $1.85 per M ft^3. It would then be allowed to rise, from 1978 to 1982, at the rate of inflation plus 3.5 percent. From 1982 to the end of 1984 it would rise with inflation plus 4 percent, and beginning in 1985 natural gas would be deregulated. Controls could be reimposed, for one 2-year period, after 1985 if prices began rising too steeply.

—Extend price controls to intrastate gas consumed in the State of production.

—Protect residential consumers by allocating new, more expensive gas to industry and other nonhousehold users until its price becomes equivalent to substitute fuels such as heating oil (which currently sells for the equivalent of $2.60 per M ft^3).

The compromise agreement is expected to result in a doubling of the wellhead price of new gas by 1985, although prices to consumers will not rise that steeply because of the preferential allocation of "old" gas, and because the wellhead price constitutes only about one-third of the total cost of pumping and distributing natural gas. Nonetheless, most estimates are that the plan will result in an additional $16 billion in consumer costs by 1985.[17]

ENERGY TAXES

The cornerstone of the President's energy plan was a crude oil equalization tax, which would require the first purchaser of domestic

[16] Washington Post, Mar. 8, 1977, p. A1.
[17] New York Times, Mar. 9, 1978, p. 45.

oil (generally, the refiner) to pay the difference between the controlled domestic price and the world price as set by the Organization of Petroleum Exporting Countries (OPEC). It was anticipated that the resultant higher prices would encourage conservation. The administration also proposed, in order to cushion this tax's impact on consumers and the ecomomy, that the revenues collected be rebated to taxpayers.

The House adopted the President's proposal. The Senate, however, was silent on the equalization tax but established an energy trust fund where the income from such a tax could be collected and expended on the financing of innovative production and conservation projects.

Energy tax conferees will not resolve these differences until after final agreement is reached on the natural gas portion of the plan. However, on the day that the gas compromise was announced, Senate Finance Committee Chairman Russell Long was quoted as saying:

> In my view the crude oil equalization tax could not be passed by the Senate, as of now, under any imaginable set of circumstances. . . . I tried to tell the administration that if we passed that social security increase, the public would be so tax-conscious that it would be difficult to pass another tax increase of any sort.[18]

E. Domenici-Church Amendment

When tax conferees meet, they will also consider the Domenici-Church Refundable Tax Credit for the Elderly, adopted by an 88–2 Senate vote.[19] That amendment would provide, in taxable years 1978–85, a refundable rebate of $75 to elderly households with adjusted gross incomes of up to $7,500. The credit would be phased out, at a rate of $15 for each additional $1,000 income, resulting in its loss above the $12,500 level. Older Americans will receive about $1 billion annually in financial assistance to defray rising energy costs if conferees adopt this provision.

During Senate debate on this amendment, Senator Domenici stressed the need for relief and the fairness of this method of extending it:

> Basically, we have provided no assistance to those people who are most hurt and least able to make ends meet because of the energy crisis and its ever-increasing utility bills . . . we all know that $75 would be a significant aid and asset to those senior citizens who live on a fixed income. . . . We selected the refundable tax credit because it is a simple and easy mechanism for providing relief to more than 10 million elderly households and another 6 million aged individuals who live alone . . . the Congress—in its collective wisdom—has on many occasions used tax incentives to achieve socially desirable objectives. Our amendment is consistent with previous practice. . . . We must not put our senior citizens in a position of having to choose between heating their homes or eating.

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[18] Source cited in footnote 16.
[19] For Senate debate and adoption, see Congressional Record, Oct. 27, 1977, p. S17885.

Committee Chairman Frank Church added:

> . . . the hearings held by the Special Committee on Aging made it clear that older Americans have been hard hit by rising energy costs . . . those hearings revealed that home heating expenses this past winter ranged between one-fourth and one-third of the disposable income of our retired elderly people. . . . This is really a modest effort, but an important step for those struggling on limited income. The formula is practical. It would aid the elderly in greatest need . . . the refundable tax credit can provide welcome and overdue relief. . . .

III. OTHER DEVELOPMENTS

A. Crisis Intervention

As noted in section II of this chapter, the Congress responded to the extreme weather of the winter of 1976–77 by appropriating $200 million for crisis intervention by the Community Services Administration.[20] Those funds were allocated to the States under a formula based on the severity of the winter; the relative cost of fuel; the number of low-income households; and the number of poor households headed by elderly individuals. These moneys were available for direct payments to utilities of up to $250 on behalf of individuals whose income did not exceed 125 percent of the poverty level; the elderly were one of the groups accorded priority for assistance. Funds unexpended as of August 31, 1977 were reprogramed to the CSA weatherization program.[21]

This effort has been criticized as being too late and too short-lived. Administrative problems also developed in some localities due to strict interpretations of the guidelines for the use of the funds—for example, the District of Columbia failed to allocate 40 percent of its crisis intervention moneys although thousands of unfilled applications for assistance were still pending.[22]

Despite the report of a House subcommittee alleging mismanagement, waste, and employee fraud within CSA,[23] the House approved, by a 182–181 vote, a second $200 million round of funding for crisis intervention by the agency for the winter of 1977-78.[24]

B. Warnings on Accidental Hypothermia

At the Committee on Aging "energy impact" hearings, National Institute on Aging (NIA) Director Robert Butler warned:

> A shortage of energy to maintain proper indoor temperature, if combined with the reduced ability of older persons to compensate for temperature changes can, therefore, have devastating effects on the aged.[25]

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[20] Public Law cited in footnote 5. During this crisis, area agencies on aging were instructed to utilize Older American Act funds for emergency assistance to older persons; AoA-IM-77-24, Feb. 9, 1977.
[21] Reprograming guidelines were published in the Federal Register, Jan. 12, 1978, p. 1816–17.
[22] Washington Post, Dec. 19, 1977, p. C1
[23] Washington Post; Aug. 12, 1977, p. A14.
[24] House debate appears in the Congressional Record, Dec. 6, 1977, pp. H12663-78. These funds became available when the House discontinued its opposition to the discontinuance of the B-1 bomber program. 1978 Supplemental Appropriations, Public Law 95-240, Mar. 7, 1978.
[25] Hearings cited in footnote 1, part 4, p. 265.

In December 1977, the NIA undertook an information campaign to emphasize that energy conservation measures being undertaken by conscientious Americans could, for the elderly in some cases, produce fatal results. Accidental hypothermia is a threat for the 10 percent of older Americans suffering from diseases of the circulatory system, hypothyroidism, or taking phenothiazine antidepressant drugs. Diabetics and stroke victims are also high-risk candidates for this sudden loss of body temperature. The NIA has advised all elderly persons to maintain a home temperature of at least 70 degrees farenheit.[26]

C. Warnings on Insulation Fraud and Dangers

Americans have perhaps responded more strongly to the President's call for improved home insulation than to any other portion of the energy plan. Federal Trade Commission (FTC) Chairman Michael Pertschuk estimated to the House Commerce Committee that insulation installations in homes jumped from 2.6 million in 1976 to 6 million in 1977.[27] Unfortunately, the high demand for insulating materials has resulted in price increases, deceptive claims by some manufacturers, and the sale of some products which can become corrosive or highly flammable.

The FTC has taken action to remedy this situation. In November 1977, it sent notices to hundreds of insulation manufacturers and retailers warning them of the illegality of "false or misleading" energy savings claims and failure to disclose fire or other safety risks. Each violation would be liable to a fine of up to $10,000. The FTC is also readying new trade rules which would provide consumers with standard, accurate ratings of the material's energy-saving ability.[28]

D. State Actions

During the past year, many State utility regulatory agencies, and State legislatures have taken actions to encourage energy conservation and promote rate equity. For example:

—"Lifeline" utility rates were adopted in New Jersey and Colorado.
—Low and moderate income Ohio elderly are now eligible for a 25 percent rebate on their winter fuel bills.
—Declining block-rates were abolished, and peakload pricing established, in Massachusetts.
—The use of automatic fuel adjustment clauses by electric utilities was severely restricted in Virginia.

FINDINGS AND RECOMMENDATIONS

Energy prices have shot upward at a recordbreaking pace since 1973—in large part because of the oil embargo, energy shortages, and other factors. All Americans have been affected in one form or another, but the elderly have been especially hard hit, particularly those living on limited incomes.

[26] Further details about hypothermia's symptoms and treatment are available in "Accidental Hypothermia: A Winter Hazard for the Old," U.S. Public Health Service, DHEW Publication No. (NIH) 78–1464.
[27] Washington Post, Feb. 25, 1978, p. D2.
[28] Wall Street Journal, Dec. 1, 1977, p. 33.

The energy cost squeeze affects older Americans in many other ways. Failing health or limited income may make it difficult or impossible to perform necessary repairs or to conserve fuel or energy.

Hearings conducted by the Committee on Aging in 1977 make it clear that elderly persons have been drastically affected by the rapid rise in energy prices since 1973. Energy costs for aged households with incomes not exceeding $5,000 increased from 45 percent in the Western States to almost 68 percent in the North-Central States from 1973 to 1976.

Elderly households in the Northeast with disposable incomes under $5,000 spend more than $1 out of every $4 for energy. Similarly situated households in the West spend almost 16 percent of their disposable income for energy.

Increases in Federal income maintenance programs have not kept pace with rising energy costs in recent years. Social security and supplemental security income benefits increased about 28 percent between 1973 and 1976. However, energy price hikes were substantially greater: Forty-two percent for electricity, 58 percent for natural gas, and 83 percent for fuel oil.

The committee recommends that:

—The Domenici-Church energy tax credit amendment (see pp. 49–50 for more detailed information) be enacted into law.

—Weatherization programs be substantially increased with special attention to employing older workers to assist aged homeowners.

—Consideration be given to establishing a special elderly Consumer Price Index to measure more precisely the impact of inflation upon their limited income.

—Effective outreach efforts be initiated to alert older Americans about programs, whether they be crisis oriented or otherwise, to help them.

CHAPTER IV

HEALTH GOALS: COST CONTAINMENT, "ALTERNATIVES," CURBING FRAUD AND ABUSE

The Senate intensified attention during 1977 to two urgent issues directly related to the availability and quality of health care for all Older Americans.

In the face of rapidly rising health costs, the Administration proposed, and Congress began consideration of, hospital cost containment measures.

In addition, the Senate Committee on Aging renewed exploration of alternative systems of health care for long term, chronically disabled elderly, through a series of hearings on "Health Care for Older Americans: The 'Alternatives' Issue."

I. HEALTH COSTS RISING

> Clearly understood among the American people is the absolute explosion in terms of hospital costs in our country in recent times. Hospital rooms that 25 years ago cost $15 per day are over $176 today. There has been an explosion in terms of the hospital bills which the average American family has to pay, either out of their pocket or through some kind of an insurance program.
>
> Whether they realize it or not, they are working longer and longer every year in order to receive their health care coverage. And the average worker now who is covered with some form of hospitalization is working anywhere from 4 to 5 weeks annually to be able to receive coverage.[1]

What is perhaps not so clearly understood is that this burden of escalating health costs is just as heavy, if not even more oppressive, on retired and fixed income older Americans as it is on younger persons. The cost-sharing amounts under medicare continue to increase, and the gaps continue to widen between those items and services covered by medicare and medicaid and those which must be met out-of-pocket by individual older Americans.

A. Inflationary Trends

During fiscal year 1975, total national health expenditures were approximately $122 billion, representing $564.35 per man, woman, and child in the population. These expenditures were 8.4 percent of our Nation's gross national product and represented a 15 percent increase over the previous year.

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[1] Senator Edward Kennedy, opening statement at a hearing on the Hospital Cost Containment Act of 1977, Subcommittee on Health and Scientific Research of the Senate Committee on Human Resources, Washington, D.C., May 24, 1977.

During fiscal year 1976, total national health expenditures increased another 14 percent, totalling approximately $139 billion, or $637.97 per capita; 8.6 percent of gross national product.[2]

As the table below shows, the costs of hospital care and nursing home care have exhibited the sharpest increases: Since 1960, total national health expenditures for hospital care have increased by almost 552 percent, while expenditures for nursing home care have increased an astounding 2,108 percent. During fiscal year 1976, hospital expenditures alone accounted for 39.8 percent of total health expenditures and nursing home care expenditures accounted for 7.6 percent.[3]

NATIONAL HEALTH EXPENDITURES BY TYPE OF EXPENDITURE, AMOUNTS SELECTED FISCAL YEARS, 1960–76 [1]

[Aggregate amounts in millions]

Fiscal years	Total	Hospital care	Physicians' services	Dentists' services	Drugs and drug sundries	Nursing home care	Other health services and supplies [2]	Research and medical facilities construction
1960	$25,856	$8,499	$5,580	$1,944	$3,591	$480	$4,068	$1,694
1965	38,892	13,152	8,405	2,728	4,647	1,271	5,461	3,228
1970	69,201	25,879	13,443	4,473	7,114	3,818	9,338	5,137
1975	122,231	48,224	22,925	7,810	10,269	9,100	16,324	7,579
1976 [3]	139,312	55,400	26,350	8,600	11,168	10,600	18,904	8,290
1976—aged [4]	34,853	15,775	5,863	722	2,777	8,032	[5] 1,683	----------
1976—aged expenditures as percent of total	25.02	28.47	22.25	8.4	24.87	75.77	----------	----------

[1] Adapted from chart, "National Health Expenditures by Type of Expenditure, Amounts and Percent Distribution, Selected Fiscal Years, 1929–76," Report cited in footnote 2, p. 4.
[2] Includes other professional services, eyeglasses and appliances, expenses for prepayment and administration, Government public health activities, and other health services.
[3] Preliminary estimates.
[4] Health expenditures for the aged (age 65 and over) from "Age Differences in Health Care Spending, Fiscal Year 1976," Social Security Bulletin, vol. 40, No. 8, August 1977, U.S. Department of Health, Education, and Welfare, Social Security Administration, p. 10.
[5] Includes other professional services, eyeglasses and appliances, and other health services only.

From 1974 to 1976, inflationary price increases accounted for approximately 78 percent of the rise in health and medical costs; changes in the population, particularly the increasing aged population, accounted for 5.7 percent of the increase; and changes in the types and kinds of health services provided such as increased technology, new medical services and treatments, and changes in utilization patterns accounted for 15.9 percent of the increase in personal health care expenditures.

Over a longer period, however, from fiscal year 1950 to fiscal year 1976, the Social Security Administration estimates that 54.6 percent of the total increases in personal health care spending are accounted for by price increases; 10.5 percent by population changes; and 34.9 percent by changes in the patterns and utilization of care available and received.[4]

The public spending share of national health expenditures has also increased rapidly, primarily as a result of medicare and medicaid. During fiscal year 1960, before the advent of medicare, public ex-

[2] "Health Care Expenditures and Their Control," The Health Staff, Education and Public Welfare Division, Congressional Research Service, Library of Congress, May 25, 1977, pp. 2–3. Estimates include all public and private spending for health services, construction, and research.
[3] Report cited in footnote 2, p. 3. Preliminary estimates.
[4] Report cited in footnote 2, p. 7.

penditures accounted for 24.7 percent of total national health expenditures. Public expenditures accounted for 42.2 percent of total national health expenditures for all age groups during fiscal year 1976.[5]

For health care received by the elderly, public expenditures, including medicare and medicaid, accounted for 67.7 percent during fiscal year 1976.[6]

In fiscal year 1976, spending for the health care of the elderly was 17 percent higher than it was in the previous year, reaching $34.8 billion, 25 percent of total health expenditures.[7]

B. Impact on the Aged Population

As the following statistics show, higher health care costs have a direct impact on the out-of-pocket share of health care costs borne by older Americans themselves: [8]

—Per capita personal health expenditures for the elderly have increased 37 percent from 1974 to 1976. (In 1974, personal expenditures were $1,109.54; in 1975, $1,335.72; in 1976, $1,521.36.)

—In 1976, medicare benefits paid only 43 percent of all the health expenses of the elderly. If medicare premium payments and cocharges made by the elderly themselves are deducted, medicare paid for only 38 percent of all health expenses of the elderly.

—Medicaid paid for an additional 16 percent of health care expenditures for the elderly in 1976.

—The aged themselves, or their families, paid 27 percent of all medical expenses in 1976, representing $404 per person. This figure does not include any private health insurance premiums or medicare premiums and cocharges paid by the elderly themselves.[9]

MEDICARE OUT-OF-POCKET SHARE AGAIN INCREASES

In September 1977, the Department of Health, Education, and Welfare announced an increase of 16 percent in the deductible amount for medicare part A, hospital insurance, to take effect in January 1978.

During 1977, the part A deductible was $124; for 1978 the deductible increased to $144.[10] In addition, the coinsurance charges for long-term hospital and skilled nursing home stays, which are linked to the deductible, increased by about 16 percent.

During 1977, medicare beneficiaries hospitalized from the 61st day to the 90th day paid $31 per day; during 1978 they will pay $36 per day. Medicare patients drawing upon their 60-day lifetime reserve will have their daily coinsurance charge boosted from $62 during 1977 to $72 during 1978. For a post-hospital stay of from 21 to 100 days in a skilled nursing facility, the daily coinsurance charge rose in January 1978 to $18 from the 1977 level of $15.50.

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[5] Estimated. Report cited in footnote 2, p. 10.

[6] "Social Security Bulletin," vol. 40, No. 8, August 1977, p. 10. This is a slight increase from fiscal year 1975, when public expenditures accounted for 66 percent. These figures include medicare premiums, which are paid out-of-pocket.

[7] Reference cited in footnote 6.

[8] Reference cited in footnote 6.

[9] The proportion of total medical expenses paid directly by the elderly themselves has remained fairly constant, but the dollar amounts have increased steadily. In 1975, the elderly paid 26.3 percent of total medical expenses, or $351 per person. In 1974, 28 percent of total medical expenses were paid directly—$311 per person.

[10] This increase is mandatory under existing law, which requires the deductible to be adjusted annually according to changes in average per diem hospital costs covered by medicare.

On January 3, 1978, the Department of Health, Education, and Welfare announced that the monthly premium for medicare part B, supplementary medical insurance, which pays for doctor visits and other out-of-hospital medical expenses, will increase to $8.20 per month from the current level of $7.70 per month, effective July 1978. The monthly medicare part B premium has climbed steadily from $3 a month when the program began in July 1966.

Senator Frank Church, Chairman of the Senate Committee on Aging, and Senator Harrison Williams, Chairman of the Senate Human Resources Committee, introduced legislation (S. 2190) on October 11, 1977, to give the Secretary of HEW authority to disapprove all or a portion of the scheduled 16 percent increase in medicare hospital charges. Representative Claude Pepper, Chairman of the House Select Committee on Aging, introduced a bill on September 16, 1977, to delay for 6 months, until July 1978, the scheduled increases. No action, however, was taken on these bills.

ELDERLY MEDICAID RECIPIENTS DECREASE FOR SECOND YEAR

The fiscal year 1979 budget estimated that 3.47 million elderly (those age 65 and over) will receive medicaid benefits during fiscal year 1979—approximately 12 percent of all recipients.[11]

This estimate represents a decrease of 97,000 older Americans from fiscal year 1978 estimates, and a decrease of 197,000 older Americans from fiscal year 1977 estimates—when the elderly represented approximately 17 percent of all medicaid recipients.

The budget offers no explanation for these decreases, but reasons may include State cutbacks in medicaid-covered services and social security beneficiaries rising slightly above State income eligibility levels as a result of recent OASDI and SSI benefit increases.[12]

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[11] "The Budget of the U.S. Government, Fiscal Year 1979," Executive Office of the President.

[12] See chapter I for discussion of cost of living increases in social security and supplemental security income benefits. Section 503 of Public Law 94-566, passed by Congress in October 1976, authorized cost of living increase disregards for persons entitled to medicaid because they receive SSI payments or State supplemental payments. The protection was not extended, however, to non-SSI recipients with low incomes, such as other OASDI beneficiaries. This provision protected approximately 30,000 persons nationwide from losing their medicaid eligibility as a result of the SSI cost of living increase which went into effect in July 1977.

In a letter to HEW Secretary Califano on December 6, 1977, Senator Church asked for information on how many elderly individuals currently receiving medicaid lost their eligibility as a result of the July 1977 OASDI benefit increase. The Department reported that data is not available on the number of elderly who may have been made ineligible for medicaid payments as a result of the July 1977 cost of living increase, but persons in 16 States which do not offer "medically needy" programs could lose all medicaid coverage due to small increases in income.[13]

C. Growing Concern About Trends in Chronic Care: The High Cost of "Institutional Bias"

Projected increases in the elderly population, coupled with a leaning in Federal health financing programs toward costly institutional forms of long-term care, provide reasons for growing concern about the structure of our Nation's long-term care health delivery system.

The Congressional Budget Office estimates that total national spending for long-term medical services in fiscal year 1976 was between $18 and $20 billion.[14] Of this, approximately 45 percent, or $8 to $10 billion, was paid for by private sources, with the major share of these private payments coming directly from consumers.[15]

Of this estimated total spending for long-term medical services in fiscal year 1976, the Congressional Budget Office estimates that ambulatory care or home health services represented a very small portion of the total spending: from $1.1 to $1.4 billion. From $14 to $16 billion went to nursing homes or sheltered living facilities and $3 billion to long-term hospitals.[16]

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[13] Currently, 35 States provide medicaid coverage to all persons receiving SSI payments. In 15 States, medical coverage of SSI recipients is limited to those who can meet additional eligibility criteria, although those persons may deduct their medical expenses from their income to establish eligibility—often referred to as the medicaid "spend down" system.

[14] "Long Term Care: Actuarial Cost Estimates," A Congressional Budget Office Technical Analysis Paper, August 1977, Congressional Budget Office, U.S. Congress, Washington, D.C., p. 11. See following table for description of "long-term medical services".

[15] The CBO estimates that direct consumer payments were $7 to $9 billion. The remainder was paid by private insurance policies or philanthropic organizations. See following table.

[16] Report cited in footnote 14.

SOURCES AND USES OF FUNDS FOR LONG-TERM CARE SERVICES, FISCAL YEAR 1976 [1]

[Dollars in billions]

	Total, all sources	Private				Total public	Federal outlays					State and local outlays		
		Total	Out of pocket [2]	Insurance	Other		Total	Medicare [3]	Medicaid	VA	Other	Total	Medicaid	Other
All services	18.1–20.4	7.7–9.9	6.9–8.9	0.5	0.4–0.6	10.4–10.5	5.0	0.6	3.2	1.0	0.2	5.5	2.5	2.9
Institutional care	[4] 17.0–18.9	7.5–9.3	6.7–8.4	.4	.4–.6	9.6	4.5	.3	3.1	1.0	.1	5.1	2.5	2.6
Ambulatory and home care	[5] 1.1–1.4	.2–.6	.2–.5	(6)	(6)	.9	.5	.3	.1	(6)	.1	.3	.1	.3

[1] All estimates exclude administrative cost of insurance or Government programs and social services, assistance with routine chores, food preparation, etc.

[2] Includes payments by all income maintenance programs, including supplemental security income, social security, and any State supplements.

[3] Includes premiums paid by individuals for part B, supplementary medical insurance.

[4] Institutional care includes custodial services of long-term hospitals and psychiatric hospitals, all patients in facilities classified as skilled nusring facilities, intermediate care facilities, personal care homes, homes for physically handicapped, blind, deaf, and mentally retarded, drug and alcoholism facilities, and other sheltered living.

[5] Ambulatory and home care includes home health agencies, rehabilitation agencies, and private practitioners other than physicians, dentists, and others who normally treat acute illness.

[6] Less than $50,000,000.

D. The Nursing Home Share

Nursing home costs continued to rise sharply in 1977. Total industry revenues increased from $10.5 billion in 1976 to $12 billion in 1977. These costs are scheduled to increase to $14 billion in fiscal year 1978 and projected at slightly more than $15 billion in the President's 1979 budget.[17]

In 1979, the medicaid program by itself will continue to account for roughly 50 percent of total industry revenues. Payments for nursing home care continue to comprise the largest sector of medicaid outlays, almost 38 percent of total medicaid payments.[18]

Medicare's contributions to nursing home care are small by comparison. In 1975, 3 percent of medicare went to nursing homes while only 2.3 percent of medicare funds will go to nursing homes this year. In the fiscal year 1979 budget, the percentage of nursing home outlays to total medicare spending will drop to 2.29 percent.[19]

Private contributions continued to be an important source of nursing home payments in 1977. They have accounted for slightly more than 45 percent of total nursing home revenues in 1976 and 1977, and will continue to do so in 1978.[20]

E. The Future

As the elderly population increases, and as costs for medical services continue to escalate, the outlays for long-term medical services for the elderly will grow rapidly.

Estimates of total national spending for long-term medical care services, based on current programs with no legislative change, reflect a rise to between $32 and $36 billion in fiscal year 1980, and from $63 to $75 billion in fiscal year 1985.

In 1985, spending for institutional services would be from $59 to $65 billion, and skilled nursing home expenditures would quadruple by 1985 to $48.6 billion. Ambulatory and home health services expenditures would also increase, but remain a small portion of the total long-term medical services outlays—rising to $4 to $10 billion by fiscal year 1985.[21]

II. RESPONSES TO ESCALATING COSTS

Major legislation was introduced during 1977 to slow the rate of increase in the costs of acute hospital care, and new health planning guidelines were issued by the Department of Health, Education, and Welfare to address an oversupply of acute-care hospital beds and special care units.

A. Hospital Cost Containment Proposals

The administration's hospital cost containment proposal was introduced in April 1977.[22] Title I of the Hospital Cost Containment

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[17] Report cited in footnote 11.
[18] See following chapter on nursing homes and below for further discussion of medicaid nursing home and other long-term care outlays.
[19] Report cited in footnote 11.
[20] Staff communication with budget official, Department of Health, Education, and Welfare.
[21] Report cited in footnote 14.
[22] H.R. 6575, introduced in the House by Representatives Rogers and Rostenkowski on Apr. 25, 1977; introduced in the Senate by Senator Edward Kennedy on Apr. 26, 1977.

Act of 1977 would establish an overall ceiling on increases in total inpatient revenues, and provide that allowable increases would be limited to approximately 9 percent by fiscal year 1981. Title II of the bill would set permanent limits on hospital capital expenditures and set standards of no more than four hospital beds per 1,000 persons and 80 percent aggregate bed occupancy for each health planning and service area in the Nation. Exempted from the administration's proposal were chronic care hospitals, Federal hospitals, and hospitals getting at least 75 percent of their revenues from federally defined health maintenance organizations (HMO's) on a capitation basis.

Outlining areas the administration hoped to concentrate on in achieving cost savings, Secretary of Health, Education, and Welfare Joseph Califano cited the overutilization of acute-care hospitals by chronically ill patients:

> Right now there are 700,000 people in the Nation's acute-care hospitals. As many as 100,000—almost 15 percent—of them do not need to be there and could be better cared for at home, in skilled nursing facilities, or on an outpatient basis. These patients are generating excess charges of $7 million per day just for operating costs, or $2.6 billion a year." [23]

Secretary Califano estimated that the administration's hospital cost containment program would result in savings of $1.9 billion a year in the first year, and that savings to medicare and medicaid would be approximately $650 million.[24]

In May 1977, Senator Herman Talmadge, Chairman of the Health Subcommittee of the Senate Finance Committee, introduced a second major hospital cost containment measure.[25] The Medicare and Medicaid Reimbursement Reform Act would establish a new method of reimbursement for routine hospital operating costs under medicare and medicaid, providing incentive reimbursements for hospitals whose routine costs are below the average and penalties for those with costs exceeding 120 percent of the average. The bill would also encourage physicians to accept assignment under medicare by permitting them to submit simplified billing forms and providing an administrative cost savings allowance above regular payments; establish a new Health Care Financing Administration in the Department of Health, Education, and Welfare with responsibility for both medicare and medicaid;[26] and establish performance criteria for medicaid.

Hearings were held on the administration's bill in the House and by the Senate Human Resources Committee during May and June 1977.[27] The Senate Finance Committee held hearings on hospital cost containment proposals in June and October 1977.

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[23] In testimony before the House Subcommittees on Health and Health and the Environment on May 11, 1977, and before the Senate Finance Committee on June 7, 1977.

[24] Testimony cited in footnote 23.

[25] S. 1470, The Medicare and Medicaid Reimbursement Reform Act, was introduced in the Senate on May 5, 1977. A similar measure, H.R. 7079, was introduced in the House of Representatives by Representative Rogers on May 10, 1977.

[26] A new Health Care Financing Administration was created in March 1977 by an executive reorganization of health programs within HEW. See section on "Increased Attention to 'Alternatives'" for further discussion of responsibilities.

[27] An amended version of the administration's bill was ordered reported by the Senate Human Resources Committee in August 1977.

Other hospital cost containment measures were introduced during the year, but no final action was taken.[28]

This legislation remains a priority for the administration, however, and the fiscal year 1979 budget again proposed hospital cost containment legislation, citing savings to medicare part A (hospital insurance) of $630 million in fiscal year 1979. The budget estimates that this proposed legislation would also save the medicaid program $100 million during fiscal year 1979.[29]

On January 30, 1978, representatives of the Nation's health industry, including the American Medical Association and the Federation of American Hospitals, announced the formation of a national network of medical and hospital committees designed to hold down hospital costs on a voluntary basis.[30] The group announced that the goal of the voluntary effort would be to reduce the growth rate of hospital costs by 2 percent a year in each of the next 2 years.

B. Health Planning Guidelines Address Hospital Bed Oversupply

On September 23, 1977, the Department of Health, Education, and Welfare issued advance notice of proposed national guidelines for health planning [31], as required by Public Law 93–641.[32]

Proposed guidelines for general hospital beds included provisions to ensure fewer than four non-Federal, short-term hospital beds per 1,000 persons per health service area, and an average annual occupancy rate of at least 80 percent for all non-Federal, general short-term hospitals in a health service area, except under extraordinary circumstances.

On December 6, 1977, the House of Representatives passed a resolution [33] expressing a concern that the proposed guidelines would impose unrealistic performance requirements on small, rural hospitals, forcing them to close. The resolution expressed the sense of the Congress that the guidelines should include sufficient flexibility to allow a health systems agency to recognize special circumstances in rural areas.

Final rules for national guidelines for health planning were published by HEW in March 1978, which more clearly stated local flexibility in final decisionmaking.[34]

Also in January 1978, bills were introduced in the House and the Senate to amend and extend authority for health planning and health systems agencies.[35] The bills would extend titles XV and XVI of the

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[28] Including the State Cost Control Plan for Hospitals Act of 1977, introduced by Senators Schweiker and McIntyre (S. 1878) in the Senate and by Representative Rogers (H.R. 8633) in the House; and amended versions of the Administration's bill introduced in the House by Representative Rogers (H.R. 9717) and Rostenkowski (H.R. 8337).

[29] Report cited in footnote 14.

[30] New York Times, Jan. 31, 1978.

[31] Federal Register, vol. 42, No. 185, Sept. 23, 1977, p. 48502. The proposed planning guidelines for local health systems agencies covered general hospital beds, obstetrical inpatient services, pediatric inpatient services, neonatal intensive care units, open heart surgery units, cardiac catheterization units, radiation therapy, CAT scanners, and end-stage renal disease.

[32] Section 1501 of the Public Health Service Act, as amended by the National Health Planning and Resources Development Act of 1974. This law created a nationwide network of health systems agencies with responsibility for areawide health planning and certification of need for new health services.

[33] H. Con. Res. 432, passed by a vote of 357 to 0.

[34] Federal Register, Vol. 43, No. 60, Mar. 28, 1978, p. 13040.

[35] Representative Rogers introduced the Health Planning and Resource Development Amendments of 1978 in the House of Representatives (H.R. 10460) on Jan. 19, 1978. The Health Planning Amendments of 1978 (S. 2410) was introduced in the Senate by Senator Edward Kennedy on Jan. 23, 1978.

Public Health Services Act (Public Law 93–641) for 3 years. As additional measures to fight hospital cost increases, the bills include a provision to establish a program to encourage hospitals to close, merge, or convert unnecessary facilities and services on a voluntary basis. Incentives would be granted through payments to encourage planning, development, and delivery of ambulatory care services, home health care services, long-term care services, and other alternatives to hospital care. The incentive payments could also be used for the costs of construction and acquisition of equipment.

C. Pitfalls in Hospital Cost Containment?

It is clear that an overall reduction in hospital costs would carry great benefits for the Nation's elderly population as a whole, but close attention must be paid to the long-term effects of hospital cost cutting measures on the delivery of health services to the elderly.

The Committee on Aging urges that a hospital cost containment program adequately address important questions about the kind of care needed and most appropriate for our Nation's growing elderly population. A cost containment program must also assure an appropriate priority-setting if some hospital services are dropped to achieve cost savings.

A cost containment program, for example, must not force hospitals to cut some of the newer and more promising services. Many hospitals are just now beginning to develop home care departments, but the proportion is still low—just 6.8 percent of 6,592 hospitals in the United States.[36]

A program must also insure adequate safeguards against "dumping" of patients who represent long stays and higher costs. This danger was discussed during Senate hearings on the administration's bill,[37] and was raised by the Congressional Budget Office in an analysis of the bill:

> The administration's proposal could induce some hospitals to admit more patients that are inexpensive to treat, such as simple surgery cases and candidates for diagnostic testing, and to direct expensive cases elsewhere. Some expensive cases might be referred to teaching hospitals, and others might end up in county and municipal hospitals that have no choice in the patients they accept. While there would be some protection in the administration's proposal against a hospital's "dumping" charity patients and patients whose insurance pays less relative to other types of payers, there is no provision to prevent adverse selection by type of diagnosis. Neither would the proposal recognize this tendency by allowing higher growth rates for the hospitals that must treat additional expensive cases.[38]

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[36] From testimony of Judith Walden, R.N., director, Hospital Home Health Care, Albuquerque, N. Mex., at a hearing on "Health Care for Older Americans: The 'Alternatives' Issue," May 16, 1977, before the Senate Special Committee on Aging, Washington, D.C. Data collected from a survey of hospitals done by the American Hospital Association in 1975. The Bureau of Health Insurance reports even less—280 certified hospital-based home health agencies of a total 2,361 agencies certified for medicare.

[37] Senator Schweiker raised this point with Secretary Califano during a Senate Health Subcommittee (Human Resources Committee) hearing on May 24, 1977: "On quality of care, as soon as you put on a cap, administrators are going to have to worry about profit and loss: and will they not begin to look at patients with that in mind? And it seems to me that expensive patients whose care entails a great deal of extra expense are now going to become a red flag to a hospital administrator, because, with a cap, he cannot make ends meet. Now, the focus is on saving lives. But with a penalty for increasing, a penalty for decreasing, there will be a disincentive to give them maximum service."

[38] "The Hospital Cost Containment Act of 1977: An Analysis of the Administration's Proposal," prepared for the Subcommittee on Health and Scientific Research of the Committee on Human Resources, U.S. Senate, Congressional Budget Office, July 1977, p. 18.

As a group, older Americans would clearly appear to be at the most risk of "dumping" and shuffling from hospital to hospital as administrators attempt to cut costs. This may be true both because elderly patients may indeed represent longer and more expensive stays, as well as lower reimbursement.[39]

Careful attention must also be paid to incentives for the development of noninstitutional medical care, if the cost savings projected by the administration as a result of discharging inappropriately hospitalized patients are to be realized. The incentive payments to hospitals for development of alternative health services proposed in the Health Planning Amendments of 1978 [40] is a step in the right direction, but as the following section of this report illustrates, very little progress has been made in recent years in developing these alternatives. Gaps remain wide.

III. THE "ALTERNATIVES" ISSUE

The Committee on Aging conducted a series of hearings during 1977 to explore progress being made in the development of so-called "alternatives to institutionalization" for chronically ill and disabled elderly.[41]

Senator Church, Chairman of the Committee, described the "alternatives issue" in a statement at the first hearing:[42]

> My statement for this timely hearing can be summed up with one question: If costly hospital and nursing home care is inappropriate for many older persons who need sustained but not full-time attention in an institution, where are such persons to turn for help?
>
> The standard reply to that question, particularly since the White House Conference on Aging in 1971, has been that alternatives to institutional care must be developed, and among those alternatives should be home health care, home help and chore service, adult day centers for regular drop-in help, hospital-based outpatient facilities, meals-on-wheels, sheltered housing, and combinations of all these possibilities.
>
> I have some quarrel with the use of the word "alternatives," and I hope that these hearings will make the point that often there can be no substitute for the nursing home or the hospital for people who need the staff and daily routine which only an institution can provide.
>
> I tend to agree with the consultant to this committee who recently wrote:
>
> "The use of the term 'alternatives to institutional care' to describe a relatively small number of community approaches is unfortunate since it seems to imply either/or solutions with,

[39] Most hospitalization costs for the elderly are paid for through public health insurance programs and hospitals often complain that these programs reimburse at an amount less than actual cost. During fiscal year 1976, medicare, medicaid, and other public programs combined paid for 91 percent of hospital expenditures for the elderly.

[40] See discussion of legislation to extend authority for health planning and health systems agencies above.

[41] "Health Care for Older Americans: The 'Alternatives' Issue." Senator Lawton Chiles chaired hearings in Washington, D.C., on May 16, 1977, May 17, 1977, June 15, 1977, and Sept. 21, 1977, and a hearing in Tallahassee, Florida on Nov. 23, 1977. Senator John Glenn chaired a hearing in Cleveland, Ohio, on July 6, 1977. Senator Edward Brooke chaired a hearing in Holyoke, Mass., on Oct. 12, 1977. Parts 1 through 7, Hearings before the Special Committee on Aging, U.S. Senate.

[42] Hearings cited in footnote 41, part 1, May 16, 1977.

more often than not, an implied rationale based entirely on economic considerations."

In other words, we have to develop community based systems in which there is a role for institutions and a role for other forms of help, provided when people need it, in the home or elsewhere.

Senator Lawton Chiles, who chaired the hearing series, identified one of the issues addressed by many witnesses: [43]

> Five years after the 1971 White House Conference on Aging where so much was said about the need for alternatives, we can even ask whether we are making any real progress in providing them. As I have already indicated, medicare and medicaid give scant encouragement to development of non-institutional care.
>
> It could be said, however, that since the 1971 conference other funding sources have emerged. The title XX social service program under the Social Security Act is now helping pay the bill for some alternatives care. The Older Americans Act has been mandated by the Congress to make home health a priority matter. But the increase in the programs involved has also resulted in fragmented funding, widely varying eligibility requirements, and a great deal of confusion.

A. Still Without a Federal Policy

The hearings served to point out, however, that 7 years after the last White House Conference on Aging, Federal actions have not helped the Nation come any closer to realizing the goal of a comprehensive system of alternative community health and support services for the elderly than was the case then.

The hearings made it apparent, in fact, that there were still no clear-cut Federal policies in long-term care:

> When I was asked if I believe that this Nation had progressed toward providing alternatives since the White House Conference on Aging in 1971, I would be compelled to respond negatively. The reality is that we are faced with potentially decreasing those chances, rather than expanding the opportunity if we define alternatives as nonhealth care institutions.[44]
>
> * * * * * * *
>
> Older people with broad chronic health social service problems are limited to publicly supported, narrowly focused, acute medical resources. This issue, as I have pointed out, was fully outlined in 1971 before the White House Conference. As recently as last year, the Anglo-American conference put on by the Institute of Medicine and the long-term care data conference in Tucson repeated this

[43] Hearings cited in footnote 41, part 1, May 16, 1977.

[44] Testimony of Marie Callender, President, Connecticut Health Plan, Bridgeport, Conn.; former Special Assistant for Nursing Home Affairs, Department of Health, Education, and Welfare; member, National Health Insurance Task Force: Director, Office of Research and Manpower, Administration on Aging, Department of Health, Education, and Welfare. Hearings cited in footnote 41, part 2, May 17, 1977.

observation and the inappropriateness of the medical-focused system that we now have.[45]

* * * * * * *

You are quite correct that at this particular time the Department does not appear to have a consistent, well thought out set of policies with respect to alternatives. It seems to me that we should have a sense of response and accountability so that we know where to turn to see why certain things are done and not done.[46]

* * * * * * *

We have already studied a great deal about alternatives and we have not systematically, in my view, compiled that information in a way that is meaningful to policymakers so that we can go on to another stage which is to make decisions about how to implement policy on that which we know.

I believe that unless there is responsibility taken in key places in HEW, we will be no further along in 6 months or a year than we are right now.[47]

B. A New Commitment by HEW?

In March 1977, HEW Secretary Califano announced the formation of a new Health Care Financing Administration (HCFA) under a major reorganization of Federal health care financing components. HCFA was to consolidate medicare, medicaid, professional standards review, and research and statistics programs related to health care financing into one agency. The work of the new agency was to be directed to containment of health care costs and reform of Federal health care reimbursement programs.

Senator Chiles outlined the committee's concerns in an early hearing:

> Heavy emphasis is being put on reorganization and upon the need to judge objectively the effectiveness of programs. The HEW reorganization, which calls for a new Health Care Financing Administration, with responsibility for medicare and medicaid, could be constructive if it finally ends the divided administration over these two programs. But will the new Health Care Financing Administration also bear responsibility not only for reimbursement of institutional care but for all the other forms of care that an increasingly aging population will require? That is another question for HEW. If answers are not readily available, this committee will certainly work together with HEW to make certain they are forthcoming.[48]

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[45] Testimony of Stanley J. Brody, professor for social planning, departments of physical medicine, rehabilitation, and psychiatry, school of medicine; and professor of health care administration, Wharton School, University of Pennsylvania. Hearings cited in footnote 41, part 2, May 17, 1977.

[46] Testimony of Dr. Robert Butler, Director, National Institute on Aging, National Institutes of Health, Department of Health, Education, and Welfare. Hearings cited in footnote 41, part 3, June 15, 1977.

[47] Testimony of Robert Derzon, Administrator, Health Care Financing Administration, Department of Health, Education, and Welfare. Hearings cited in footnote 41, part 3, June 15, 1977.

[48] Opening statement, hearings cited in footnote 41, part 1, May 16, 1977.

At a later hearing with administration witnesses, Senator Chiles again pursued this question of assignment of responsibility for long-term care program alternatives within the Department of Health, Education, and Welfare:

> Mr. Derzon . . . the important question is the one that we talked about at our last meeting. When and where are we going to have a focal point for long-term health care development within the Department of Health, Education, and Welfare? I think you agreed with me last time that this was essential. Our frail and elderly population is growing every day and in trying to develop alternatives the planning is already overdue.
>
> It seems since our last meeting in June, the only changes I am aware of seem to represent a further diffusion of responsibility. You are telling me how you are going to divide this up between the groups in the Department, and there are good and valid reasons for dividing it up; but I want to know who is going to be the captain of the ship and who do we look for and who do the people look for and where is the focal point? [48a]

In October, the administration made a commitment to the committee to make the development of community systems of long-term care a high priority. The HEW response was made available to Senator Chiles in late October 1977.

HEW Secretary Califano said:

> Long-term care involves a complicated issue which will require continuous effort and coordination to develop consistent policy throughout the Department. I recognize that the operations and policy development work of many offices throughout the Department affect long-term care policy. And while these offices will carry on with their present operating responsibilities, it is critical that a central focal point be established to ensure that HEW policy is consistent and that it is developed in a timely and coordinated fashion that meets congressional deadlines as well as our own needs.
>
> I believe there is little disagreement in HEW on the merits of supportive services to keep the elderly and chronically disabled in their communities. The larger and more difficult questions are financing and administrative feasibility.[49]

HCFA was designated as the focal point in development of Departmental policies on long-term care and the following timetable of activities was transmitted to Senator Chiles:

> 1. *Home Health Analysis*—December 1978. This will be a major effort conforming essentially to the provision for a full study of home health services outlined in H.R. 3, The Medicare and Medicaid Fraud and Abuse Act. Major areas to be studied include availability, administration, provision, reimbursement, and cost of home health and other in-home

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[48a] Hearing cited in footnote 41, part 5, Sept. 21, 1977.

[49] Memo to Administrator, Health Care Financing Administration, from Joseph A. Califano, Jr., Oct. 21, 1977.

services under titles XVIII, XIX, and XX. Interprogram coordination issues, utilization control, and prevention of fraud and abuse are other issues that will be included in our report to Congress.

2. *National Health Insurance and Long-Term Care*—March 1978. The administration plans to propose national health insurance legislation early in 1978. An integral issue in NHI is how long-term care services should be treated. This analysis has already begun and will continue as plans for the overall proposal are formulated.

3. *Development and Testing of Major Structural Reforms*—Development, December 1978; Project Implementation Through 1982. In order to eliminate problems of fragmentation and institutional biases in long-term care, we plan to develop and test major alternative service delivery and financing methods. The general goals of these efforts, which will be of a long-range nature, will be to test models for coordinating services and providing a community based continuum of care for the population at risk. We will test various service combinations, organizational and administrative arrangements, and types of financing. Developmental work will take place during the next year, and demonstrations should run for 3 years after that. We believe that such a comprehensive and long-range effort is necessary in order to answer questions about needs for and costs of services under differing organizational and financing arrangements.

4. *Analysis of Program Benefits*—August 1978. During the next year we will undertake analyses of the results of the section 222 experiments and other relevant data to assess the feasibility of including such benefits as homemaker and day care services in medicare and medicaid. We will also continue our current activities aimed at improving the provision and assessment of the quality of institutional and noninstitutional long-term care, including the analysis of reimbursement issues, incentives, and greater involvement of consumers, providers, and health planners.[50]

The home health analysis promised to Congress by December 1978, was mandated by Public Law 95–142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments.[51] Section 18 required HEW to submit to Congress, within 1 year, a report "analyzing, evaluating, and making recommendations with respect to all aspects (including the availability, administration, provision, reimbursement procedures, and cost) of the delivery of home health and other in-home services authorized to be provided under titles 18 [medicare], 19 [medicaid], and XX [social services grants to States] of the Social Security Act."

The law requires the report to include recommendations regarding the scope and definition of services, eligibility requirements, service standards, procedures for control of utilization and quality assurances, reimbursement methods, and prevention of fraud and abuse.

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[50] Letter to Senator Lawton Chiles, Senate Special Committee on Aging, from Robert Derzon, Administrator, Health Care Financing Administration, Oct. 27, 1977.

[51] Signed into law on Oct. 25, 1977. See for further discussion of provisions of this law.

HEW has begun work on this report, which will include an analysis of the in-home services provided through the aging network under titles III and VII of the Older Americans Act.

C. Which Way Next?

Committee on Aging hearings during 1977 and recent reports issued by the Congressional Budget Office [52] and the General Accounting Office [53] offer compelling reasons for a closer attention to the development of community alternatives to institutional health care.

An estimated 1.6 million people of all ages were institutionalized in chronic hospitals and facilities for the deaf, blind, and disabled, in nursing homes, and in personal or domiciliary care facilities in 1976. The Congressional Budget Office estimates that this institutionalized population will increase to 2.1 million in 1980 and 3 million by 1985. Between 80 percent and 90 percent of this institutionalized population is elderly.

The majority of disabled persons, however, are not in nursing homes or other long-term care institutions. Most are living in the community. The Congressional Budget Office estimates that in 1975 the range of noninstitutionalized functionally disabled individuals was between 3.9 to 8.3 million, and that this range is expected to increase to between 4.2 and 9 million in 1980 and 4.5 to 9.6 million in 1985.

These estimates of potential need for community support services are confirmed by a recent study conducted by the General Accounting Office in Cleveland, Ohio, which estimated that 23 percent of Clevelands' noninstitutionalized over 65 population were impaired in four or more of five functional areas, therefore requiring some assistance and help from community sources.[54]

Approximately 5 million elderly alone may now be in need of some form of community support if this estimate is true of the Nation.

The Congressional Budget Office estimated that from 800,000 to 1.4 million functionally disabled individuals were receiving no form of care in 1975.[55]

The report estimated that home health care and day care services were available to between 300,000 and 500,000 persons in 1976. At the most conservative estimate, the demand for adult day care and home health care exceeded the supply by 1.5 million people.

The demand for personal care homes, sheltered living arrangements and congregate housing also far outshadowed the estimated supply in 1976. Again, at the most conservative estimate, over 1 million persons were not served.

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[52] "Long-Term Care for the Elderly and Disabled," Budget Issue Paper, Congressional Budget Office, Congress of the United States, Washington, D.C., February 1977.

[53] "The Well Being of Older People in Cleveland, Ohio," report to Congress by the Comptroller General of the United States, Apr. 19, 1977, Report No. HRD-77-70.

[54] Report cited in footnote 53. The five areas of human functioning which were assessed in the study were social status, economic status, physical health, mental health, and ability to do daily tasks. Other findings of the study were that family and friends constituted a large source of services (9 out of 10 people sampled received some service from family or friends); that impaired older people received a variety of services from 118 different social service agencies. Of the more than $74 million spent in Cleveland in 1975 to provide support, $58.6 million was for health services under medicare and medicaid and income support through supplemental security income. Of the remaining $15.7 million flowing through social service agencies, 60 percent was Federal, 26 percent private, 10 percent city, and 4 percent county. This $15.7 million went through 84 local agencies and came from 23 Federal programs administered by 7 Federal agencies.

[55] Report cited in footnote 52.

LONG-TERM CARE ESTIMATED SUPPLY AND POTENTIAL NEED, FOR CALENDAR YEAR 1976, ADULTS

[In millions]

Type of treatment	Estimated potential need	Estimated supply
Nursing home care:		
Skilled care	0.7	0.9
Intermediate care	.6	.4
Personal care homes, sheltered living arrangements, and congregate housing	1.5–1.9	.3–.8
Home health care and day care	1.7–2.7	.3–.5
Informal family care only or no care	1.0–4.0	3.6–7.2

Source: CBO estimates.

COST QUESTIONS UNRESOLVED

> Home services have constantly been required to prove they cost less money. Less money than what? Hospital care, nursing home care, intermediate care? Hospital and true skilled nursing home care, yes; but why intermediate care? . . . If we were to divert even a portion of the resources of this program to home care, it would be better use of the health care dollar. . . . To continue our present posture into the foray around national health insurance will only serve to delay an alternatives program and spend many more billions of dollars inappropriately. We have, to date, articulated a national policy on alternatives in spite of the statements that we have none. What present policy so dramatically displays is that alternatives is not a program we wish to pay for, as long as that alternative is a person's private home, or if it is a living expense rather than a health care expense.[56]

While there is continuing debate and testing of questions of cost effectiveness of home services, it remains true that definitive answers on cost effectiveness cannot be achieved until much more progress is made on the development and provision of alternative services.

A second report issued by the General Accounting Office during 1977, however, has provided some new insights.[57] At the conclusion of their 2-year study in Cleveland, GAO reported:

> Until older people become greatly or extremely impaired, the cost for home services, including the large portion provided by families and friends, is less than the cost of putting these people into institutions. To put these same people in public institutions would cost the public more because public agencies are spending fewer dollars per person than are spent for institutional care.

The GAO estimated that only about 10 percent of the noninstitutionalized elderly population are at a level of impairment in which the cost of required home services, including the value of services provided by family and friends, are equal to or greater than the costs of institutional care. This is largely true, however, because family and

[56] Testimony of Marie Callender before Senate Committee on Aging, hearing cited in footnote 44.
[57] "Home Health—The Need for a National Policy to Better Provide for the Elderly," report to the Congress by the Comptroller General of the United States, Dec. 30, 1977, Pub. No. HRD-78-19.

friends are providing up to 80 percent of the needed support at the more impaired levels.

The GAO report concluded:

> The true costs of maintaining the elderly and sick in their own homes have been largely hidden because the greatest portion of such costs represent the services provided by families and friends rather than those provided at public expense. The importance of the family and friend is evidenced by the fact that the greatly or extremely impaired elderly who live with their spouses or children generally are not institutionalized whereas those who live alone usually are. Thus, the potential for home health benefits as an alternative to institutionalization depends largely on a person's living arrangements.

A number of other experiments designed to measure the comparative costs of expansion of home-delivered services and institutional-based services are now nearing completion [58] and more information will be available during 1978 and beyond which will be of use to policymakers as a national long-term care policy is fashioned.

PROGRAM FLEXIBILITY AND THE CURRENT INVESTMENT

> "As we address the issue of alternatives to institutionalization, our prime concern should be the wishes of the older persons themselves. The desire to remain independent is a compelling force in the lives of the elderly, and should be reinforced by whatever methods we can devise." [59]
>
> —Senator Pete Domenici.

> "We have to develop community based systems in which there is a role for institutions and a role for other forms of assistance, based on what people need, when they need it, provided in the most appropriate setting. In order to do this, we must achieve a mix of what are now strictly defined 'health' services and 'social' services. Achieving this mix at the local level is one of the most challenging problems we now face." [60]
>
> —Senator Frank Church.

The confusion between what is health, and allowably financed out of the national health care dollar, and what is social service, and allowably financed out of the national social service dollar, is evident when the major Federal sources of funding for "alternative" services are examined.

Witnesses during Committee on Aging hearings also offered substantial evidence of the challenges this presents to practitioners:

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[58] Public Law 92-603, the 1972 amendments to the Social Security Act, authorized the conduct of experiments and demonstrations to determine the costs of providing day care and homemaker services as alternatives to present medicare home health benefits and to determine their effectiveness in preventing or delaying institutionalization. The experiments have been completed, and the Health Care Financing Administration and the Public Health Service are now analyzing the results.

[59] Statement of Senator Pete V. Domenici, hearings of the Senate Committee on Aging cited in footnote 41, part 1, May 16, 1977.

[60] Statement of Senator Frank Church, hearings of the Senate Committee on Aging cited in footnote 41, part 3, June 15, 1977.

Because of the wide variety of services needed and the many different Federal programs covering the cost, On Lok, like other similar programs, is forced to look to many different Federal, State, and local funding sources for support. Each of these has its own rules and requirements. Instead of getting reimbursement for services offered, programs have to be manipulated to meet the needs of the funding sources and their administrators. In addition, we get caught in the game of musical chairs, where Federal agencies refer us to local and State resources, and they in turn send us right back to Washington. I leave it to your imagination to figure the costs of such games to small projects as ours.[61]

* * * * *

The tremendously complex tasks of dealing with variations in eligibility for our patients under titles XVIII, XIX, and XX of the Social Security Act, and titles III and VII of the Older Americans Act can be disheartening if not overwhelming.

The problem is also one of lack of "crosswalks" from one program to another. Realignment of these programs to make them more consistent with one another would make possible the more efficient utilization of available dollars.[62]

* * * * *

Bias toward acute care permeates the health care system. This bias has sired regulatory controls that limit eligibility and funding for medicare benefits. Many chronically ill persons require more than medical care . . . Federal regulations selected a series of medically-oriented tasks and observations, defined them as "skilled" nursing care, and limited reimbursement eligibility to these tasks, thereby eliminating many preventive and maintenance services needed by the chronically ill. Judgments made by fiscal intermediaries fail to take into account extenuating circumstances that modify the level of care. For example, one patient who had eye surgery needed one drop of a rather potent medication instilled in each eye for an extensive period. The patient and her husband were both elderly, frail, and palsied. Neither one had the visual acuity or hand control needed to accomplish the treatment. Despite careful and repeated justifications, payments for visits were denied. Fortunately, the public agency continued this service.[63]

The following tables illustrate the increased Federal funding for in-home and ambulatory services during the past few years, even

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[61] Testimony of Marie-Louise Ansak, executive director, On Lok Senior Health Services, San Francisco, Calif., before Senate Committee on Aging, hearings cited in footnote 41, part 5, Sept. 21, 1977.

[62] Testimony of Robert P. Liversidge, Jr., executive director, Bath-Brunswick Regional Health Agency, Bath, Maine, before Senate Committee on Aging, hearings cited in footnote 41, part 1, May 16, 1977.

[63] Testimony of Dolores M. Wennlund, R.N., M.S., Public Health Nursing program supervisor, Department of Health and Rehabilitative Services, State of Florida, before Senate Committee on Aging, hearings cited in footnote 41, part 1, May 16, 1977.

though it represents a miniscule proportion of Federal funding for health and social services. These increases are occurring simultaneously in different programs with different requirements and different interests.

MEDICARE[1]

[Dollars in millions]

Fiscal year	Total outlays	Home health outlays	Home health outlays as a percent of total outlays
1975	$14,118	$183	1.3
1976[2]	21,521	402	1.9
1977	20,771	457	2.2
1978	24,604	607	2.5
1979	28,961	786	2.7

[1] Medicare, as a health insurance program for the aged, is not a major financer of community based long-term care services. In addition to payments for skilled nursing facility services on a post-hospital, semiacute care basis, however, it is the major funding source for all home health care. Home health care reimbursement is available for part-time, intermittent skilled mursing provided in the home as well as physical, occupational, or speech therapy; medical social services, medical supplies and equipment, and part-time home health aides, as long as a physician orders skilled nursing or therapy. Full cost is paid for up to 100 visits under medicare pt. A conditional on prior 3-day hospital stay. Up to 100 visits allowed under medicare pt. B without prior hospitalization. All outlays fron Budget of the U.S. Government. Outlays for fiscal years 1975, 1976, and 1977 are actual. Outlays for fiscal years 1978 and 1979 are estimated.

[2] Including transitional quarter.

MEDICAID[1]

[Dollars in millions]

Fiscal year	Total outlays	Home health outlays	Home health outlays as a percent of total outlays
1975	$12,086	$7.3	0.06
1976	13,977	12.6	.09
1977	16,257	[2] 146.0	.9
1978	18,158	164.0	.9
1979	20,186	183.0	.9

[1] In addition to physician, hospital, and clinical services, medicaid reimbursement is available for nursing home care (skilled and intermediate), home health, personal care services, and day care services. Most of the long-term care funds support institutional care. Currently, only 8 States have a personal care program under medicaid, therefore outlays are very small. Additional States are considering implementation, however, as title XX ceilings are reached. Medicaid regulations (issued in August 1976; effective November 1976) define home health to include nursing, home health aides, and medical supplies and equipment. All outlays from Budget of the U.S. Government, Health Care Financing Administration. Outlays for fiscal years 1975, 1976, and 1977 are actual. Outlays for fiscal years 1978 and 1979 are estimated.

[2] Precise explanations for the large increase in home health spending from fiscal year 1976 to fiscal year 1977 are not available. Part of the increase may be due to the fact that some States converted their medicaid reimbursement formulas for services to reflect "reasonable costs" during this time period, and it may be partially due to a change in reporting categories as a result of the broadened definition for home health services under medicaid prior to the fiscal yaer 1977 reporting period. Also, precise statistics are not yet available on medicaid expenditure categories, as only 20 States have yet achieved information systems which can supply totally reliable data.

Source: Health Care Financing Administration.

TITLE XX (SOCIAL SERVICES)[64]

Since 1976 was the first year of operation of this program, very little data is available concerning expenditures and recipients of services in various categories, but data reported for the 3 months

[64] States may provide a wide variety of social services to anyone who receives cash payments under aid to families with dependent children, supplemental security income, or medicaid, or has an income adjusted for family size. States can provide a wide variety of services, but they are required to provide at least three services to Supplemental Security Income recipients.

See Chapter X, p. 190 for further discussion of title XX allocations and following section, "Fragmentation: The Individual Provider Issue," for discussion of abuse of title XX funds in home care programs.

Source: "Social Services, U.S.A., Statistical Tables, Summaries, and Analyses of Services under Social Security Act Titles XX, IV-B, and IV-C for Fifty States and D.C.," April-June 1976, U.S. Department of Health, Education, and Welfare, Office of Human Development Services, Administration for Public Services, Pub. No. (OHDS) 77-03300.

ending in June 1976, indicates that $117.2 million, or 17.5 percent of total title XX expenditures during that quarter of $671.7 million, were spent on chore services, adult day care, home delivered or congregate meals, homemaker services, and home management services.

There is a wide disparity among the States, however, in definitions and key components of each service, and it is virtually impossible to compare homemaker or adult day care services funded through title XX, for instance, to those which might be funded through medicaid.

OLDER AMERICANS ACT [1]

Fiscal year	Title III		Title VII		
	Amount obligated to inhome services	Percent of total appropriation	Total funding level	Total meals served	Percent of meals served delivered inhome
1976	4,854,162	5	187,500,000	59,000,000	13
1977	16,907,525	14	225,000,000	101,090,720	15

[1] Home services are 1 of 4 national priority services under title III of the Older Americans Act and are defined as including homemaker services, home health services, shopping assistance, escort services, reader services, letter writing services and other services designed to assist older persons to continue living independently in a home environment. State and area agencies on aging are mandated to coordinate and pool local resources for elderly services and can provide funding to direct service providers if other funds are not available. Social services which may be funded include preventive services to avoid institutionalization such as periodic screening and evaluation, homemaker and home health services, chore services, friendly visiting, telephone reassurance services, protective services, and housing assistance. Title VII, the nutrition program for the elderly, authorizes funds to provide low-cost nutritionally sound meals in centers to promote better health and reduce isolation among the elderly. The program primarily provides congregate meals, but home delivered meals are also provided. See ch. VIII, p. 113 for additional information on Older Americans Act programs.

Source: Administration on Aging, Office of Human Development Services, U.S. Department of Health, Education, and Welfare.

FRAGMENTATION: THE "INDIVIDUAL PROVIDER" ISSUE

Serious questions were raised during committee hearings [65] of potential abuse in the use of title XX and medicaid funds to reimburse self-employed "home attendants" providing personal care services to home-bound elderly. New York and California witnesses questioned the quality of service given by untrained and unsupervised attendants; absence of program monitoring which presented opportunities for fiscal fraud and abuse; and unfair treatment of employees through administrative failures which, in New York, in effect withheld payment for long periods of time and did not provide for any employee benefits.

Problems experienced in the New York "home attendant" program, financed primarily through medicaid, include: [66]

—Bad treatment of employees (home attendants receive low pay with no benefits, no social security, no vacation time, no travel expenses).
—Considerable delays in payment of attendants, often for a number of months.
—Sparse, or absent, training of attendants.
—Dismissal of workers by patients for questionable reasons.
—Inadequate supervision of attendants (they report only to the patient).

[65] Testimony of Susan K. Kinoy, associate executive director for program services, Community Council of Greater New York, New York City, hearings cited in footnote 41, part 1, May 16, 1977; and testimony of Terry Bloom, director of social work, San Francisco Home Health Service, San Francisco, Calif., hearings cited in footnote 41, part 2, May 17, 1977.
[66] Testimony of Susan K. Kinoy.

—Poor screening and selection of attendants by patients or families because there is no criteria for selection and families are often so desperate for help they will settle for anyone to do the job. This has led to cases of physical and emotional abuse of patients, and patients are fearful of reporting incidents for fear of losing service.

More recent reports on New York City's program charge fraud in handling funds and $8.4 million a year in payment errors.[67]

Similar problems were reported in individual provider programs in California.[68] Homemakers and chore services are provided by persons with no training who receive supervision only from the patients themselves. Workers are hired directly by patients and patients pay the workers. Instances of both abuse of patients and workers were also outlined in the California program.

A witness described the fragmentation responsible for the birth of New York City's home attendant program and its problems:[69]

> It was brought into being precisely because medicare . . . is a health insurance program which only can provide a home health aide for short periods of time under the direct supervision of a nurse or other professional and only during such times as a person has a medical condition that is unstable or acute. . . . Title XX, on the other hand, can provide housekeeping or chore services for longer periods of time to persons who qualify below certain income levels. No requirements exist for medical supervision. . . . Title XIX—medicaid—must provide health supervision to home care workers who administer personal care. Therefore, the home attendant service uses a combination of titles XIX and XX administrative procedures. . . . Needless to say, within this very large program there has been fragmentation, immersion in bureaucratic detail with poor communication among the many agencies, resulting in long delays in service delivery, poor supervision and selection of the home attendant, lack of guidelines at both city and State level, and uncontrolled growth.

D. Proposed Legislation

The growing support in Congress for expansion of in-home services to the elderly is evidenced by the number of bills introduced during the current session of Congress. Major proposals to increase medicare and medicaid coverage for in-home health services as well as create centralized long-term care centers are receiving attention.

MAJOR "ALTERNATIVES" PENDING LEGISLATION

S. 2009, introduced by Senator Pete Domenici, would broaden medicare coverage for home services to include home health care,

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[67] The New York Times (Dec. 12, 1977) reported independent audits which found $1.5 million either unrelated to medicaid care or unverified in the city's housekeeping programs. A later State audit (New York Times, Dec. 15, 1977) found nearly $8.4 million a year in errors and fraud in the home attendant program alone. Among the abuses cited were payments made to relatives while patients were actually in hospitals. New York City will spend about $110 million in 1978 for three home care programs under medicaid—housekeepers, home attendants, and homemakers.

[68] Testimony of Terry Bloom, hearing cited in footnotes 65. Ms. Bloom testified that California had 58 different types of homemaker-chore programs in 58 counties, costing over $100 million in 1975 alone.

[69] Testimony of Susan K. Kinoy, hearing cited in footnote 65. Ms. Kinoy testified that "the last 4 years has shown an increase in usage from 2,000 to 14,000 chronically ill persons with 200 cases per month being added to the rolls."

therapy services, personal hygiene and care, light housekeeping, meal preparation, and transportation. The bill would also eliminate medicare skilled nursing requirement and requirements for prior hospitalization and home confinement. It also would allow unlimited visits under part B and would require States to provide the same services under medicaid.

S. 2288, introduced by Senator H. John Heinz III, would establish within medicare a special program of long-term care for individuals covered under medicare part B, receiving SSI payments, or eligible to enroll under medicare part B. The bill would create a Federal Advisory Council on Long-Term Care; create State long-term care agencies to organize community long-term care centers; establish a Federal long-term care trust fund. Community long-term care centers would function as providers, certifiers, evaluators, and guarantors of service. The bill also would increase SSI benefits by $36 per year to cover new medicare (part D) long-term care premium and direct the Public Health Service to provide for training of long-term care personnel.

H.R. 8589, introduced by Representative Donald Fraser, would create a long-term care trust fund financed by general revenues and create State and community long-term care agencies. Benefits covered would include home health care, homemaker services, adult day care, nutrition services, mental health outpatient services, adult foster home care, legal and professional counseling, and institutional nursing home care. All medicare eligibles would be covered, with payments based on a sliding scale.

H.R. 2029, introduced by Representative Barber Conable, would establish a long-term care program within medicare and create State and community long-term care agencies. The bill would cover all medicare eligibles and include home health, homemaker, and nutrition services as well as institutional nursing care, day care, foster home care and community mental health center outpatient services. A monthly premium of $3 would be charged.

H.R. 10738, introduced by Representative Claude Pepper, would remove the visit limitations, prior hospitalization and homebound requirements for home health services under medicare, as well as add homemaker services as a covered benefit. The bill also would seek to provide some protection against overutilization and abuse. (This bill is a more recent version of an earlier, similar bill—H.R. 1116.)

H.R. 1130, introduced by Representative Claude Pepper, would expand medicare coverage for home health care services, as well as establish community long-term care centers.

H.R. 1136, introduced by Representative Claude Pepper, would authorize an experimental program to provide in-home care including grants to families caring for elderly members; medicare coverage of day care services; construction of "campuses" for the elderly including a skilled nursing home, congregate living facility, rest home, multi-family residential facility, and a community center; and create intermediate care facilities with medicare-covered services.

H.R. 10482, introduced by Representatives William Cohen and Claude Pepper, would add a new section under title III of the Older Americans Act to provide grants to States to establish centralized

programs of long-term care assessment, referral, monitoring, evaluation, and outreach.[70]

IV. RISING CONCERN ABOUT MENTAL HEALTH

The increasing numbers of older Americans discharged from mental hospitals into communities without resources to meet their needs was documented by the Committee on Aging during hearings in 1975.[71] The committee reported then that the number of inpatients of all ages in State mental hospitals had dropped 44 percent between 1969 and 1974 (from 427,799 to 237,692). The number of elderly inpatients had decreased even more sharply, dropping 56 percent from 1969 to 1974 (from 135,322 to 59,685). Screening procedures to determine the best candidates for release were nonexistent in many States, and many elderly released to community care found themselves without attention and without help, including those placed in substandard boarding and nursing homes without access to mental health services.

Similar findings were released in 1977 by a General Accounting Office study which concluded that "mentally disabled persons have been released from public institutions without (1) adequate community-based facilities and services being available or arranged for and (2) an effective management system to make sure that only those needing inpatient or residential care were placed in public institutions and that persons released were appropriately placed and received needed services." [72]

The GAO also confirmed that many mentally disabled persons still remain in institutions unnecessarily; that patients are still being placed in substandard facilities; and that others still enter the community without appropriate services.

Unnecessary institutionalization has been documented in Florida, where 352 geriatric patients in one Florida State hospital have been identified as ready for immediate release, but are still in the institution because no one has been able to place them in the community.[73] In New York State, a survey of the mental health system found more than a quarter of the 26,000 adult patients in the State's mental hospitals were not ill enough to be kept there, but that they could not be discharged because there were not enough community facilities to support them outside the hospital.[74]

Reports released by the Administration during 1977 also serve to document the continuing crisis in mental health care for the elderly.

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[70] Senators Pete Domenici and Lawton Chiles, members of the Senate Special Committee on Aging, have also urged that the Older Americans Act be amended to encourage the Administration on Aging to focus more attention on development of long-term care services, including development of long-term care centers. In testimony before the Subcommittee on Aging of the Senate Human Resources Committee, February 1978.

[71] "Mental Health and the Elderly," joint hearing before the Subcommittee on Long-Term Care and the Subcommittee on Health of the Elderly of the Special Committee on Aging, U.S. Senate, Washington, D.C., Sept. 29, 1975.

[72] "Returning the Mentally Disabled to the Community: Government Needs To Do More," Report to the Congress by the Comptroller General of the United States, Jan. 7, 1977, Report No. HRD-76-152, p. 172.

[73] Testimony of Winsor Schmidt, representative, district II human rights advocacy committee for the Florida State Hospital at Chattahoochie, and assistant professor, department of administration, research associate, Institute for Social Research, Florida State University, Tallahassee, Fla. At hearings cited in footnote 41, part 7, Tallahassee. The Chattahoochie State Hospital has 2,316 inpatients.

[74] New York Times, Jan. 15, 1978.

A. Report of the President's Commission on Mental Health

The President's Commission on Mental Health submitted a preliminary report to the President in September, 1977,[75] which noted the prevalence of mental health problems among the elderly:

—The incidence of mental health problems is higher among people age 65 and over than other age groups.[76]

—The elderly account for 25 percent of all suicides, even though they represent only 11 percent of the population.[77]

—Between one-fifth to one-third of all people (in institutions) labeled "senile" actually have conditions which are preventable or treatable, if correctly diagnosed.

A special commission task force studying the mental health of the elderly, reporting to the commission in February 1978, called for increased efforts in outreach; development of more home care programs; broadening of medicare mental health benefits; increases in geriatric training in medical, clinical psychology, social work, and nursing curricula; accelerated research on organic brain disease; and reallocation of mental health research resources to concentrate more on the current and future mental health needs of the elderly.[78]

B. Increased Attention by NIMH

The National Institutes of Mental Health (NIMH) has announced a $3.5 million community support program to stimulate the development of community services for an estimated 1.5 million former mental hospital patients now living in the community.[79] Grants will be awarded to States to coordinate services available to former patients and to develop demonstration projects in community care and monitoring.

NIMH's forward research plan states that the principal mental disorders not now under investigation are mental disorders associated with age, noting that those over the age of 65 occupy 29 percent of all public mental hospital beds, three times their proportionate share.[80] The plan recommends a stepped-up program of clinical research on special age-related mental illness.

NIMH also recommends that title XX of the Social Security Act be amended to include mental health services, and that medicare and medicaid barriers to reimbursement of community mental health

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[75] "Preliminary Report to the President from the President's Commission on Mental Health," Sept. 1, 1977. The final report is due by Apr. 1, 1978. The Commission was established by Executive Order No. 11973, signed on Feb. 1, 1977, to identify mental health needs of the Nation and submit recommendations on how needs can be met.

[76] Comparable statistics are not uniformly available, but officials of the National Institute of Mental Health estimate that between 15 percent and 25 percent of all those over the age of 65 have "significant" mental health problems. The incidence is even higher among those over the age of 75.

[77] Estimates contained in paper presented to the National Institute of Mental Health by Dr. Calvin J. Frederick, Chief, Disaster Assistance and Emergency Mental Health Section, Division of Special Mental Health Programs, National Institute of Mental Health; and unpublished issues paper, Dr. Gene Cohen, Chief, Center for Studies of the Mental Health of the Aging, National Institute of Mental Health. Statistics on suicides in 1975 published by the National Center for Health Statistics reflect a somewhat lower rate (23 percent of all suicides occurring in age group over 60, and 16.4 percent occurring in age group over 65), but these statistics, reported through the death certificates reporting system, still reflect an incidence of suicide among the elderly much greater than their proportion in the overall population.

[78] "Mental Health of the Elderly," submitted to the Commission Feb. 15, 1978. Contained in Vol. III, "Report to the President of the President's Commission on Mental Health," Apr. 1, 1978.

[79] Washington Post, Nov. 16, 1977.

[80] "National Institutes of Mental Health, Forward Plan, Fiscal Years 1979–1983," U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, Summary, October 1977.

center services be removed to enable more elderly to participate in mental health programs.

C. Committee on Mental Health and Illness of the Elderly

The Committee on Mental Health and Illness of the Elderly [81] has submitted its final report to HEW Secretary Joseph Califano, and the report is scheduled for release to Congress during 1978.

The committee is expected to report that 80 percent of older Americans requiring mental health services do not have their needs met through existing resources, and that it is the exception rather than the rule that nursing home care includes any type of mental health services—even though from 50 to 70 percent of nursing home residents have some symptoms of mental illness.

Development of a national policy to meet the mental health needs of the elderly and establishment of a National Commission on Mental Health and Illness of the Elderly to monitor policy implementation were among the Committee's early recommendations.

The committee is also expected to recommend:

—Development of programs of preventive care and education for the elderly as well as the community at large.
—Integration of social and health services for the elderly.
—Expansion of research activities in mental illness and mental health of the elderly.
—Increased attention to training of professionals to work with mental health and illness problems of the elderly.
—Establishing prioritites to ensure that special mental health problems of minority elderly are adequately addressed.
—Expansion of mental health benefits in medicare and medicaid.

V. MEDICARE AND MEDICAID FRAUD

In 1977, the Committee on Aging continued its investigation into alleged fraud and abuse in government health care programs serving the poor and elderly. Joint hearings were held in March together with the House Ways and Means Committee to examine fraud and abuse in the home health care programs funded by medicare, medicaid, and title XX of the Social Security Act.

The hearings focused on two providers operating in the State of California. According to an audit conducted for the committee by the General Accounting Office, one provider based in San Jose charged the Government for a $145,000 salary, plus costs of a $25,000 Mercedes Benz automobile, a $35,000 mobile home and some $25,000 in reimbursed expenses. The audit disclosed that the provider placed numerous relatives on the payroll, charged their salaries in whole or in part to medicare and provided them with expense accounts and/or the use of leased automobiles.[82]

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[81] The committee was established through an amendment to Public Law 94-63, sponsored by Senator Edmund Muskie, signed into law on July 29, 1975, and extended through fiscal year 1977 by a Muskie amendment to Public Law 94-640, signed into law Oct. 8, 1976. The committee was charged with making recommendations to meet the future services, manpower, training, and research needs in mental health programs for the elderly.

[82] See "Medicare and Medicaid Fraud," hearings by the Senate Committee on Aging, part 8, Washington, D.C., Mar. 8, 1977.

Evidence was presented by John Markin, Supervisory Auditor with the General Accounting Office assigned to the House Ways and Means Committee, that the provider billed the medicare program for the purchase of personal items such as clothing and jewelry and disguised these expenses as business related meals.

The GAO analysis indicated that a former auditor with the intermediary serving this provider was in the process of conducting an audit of the home health agency and was hired away by a $35,000 salary and the offer of a Mercedes 450 SL sports car.

Along with allegations of poor care, the recurrent problem upon which the committee focused was the situation in which a provider could abuse the system by using medicare and title XX in tandem. With several overlapping corporations this California operator was able to shift most costs of operation to the medicare program. This shift allowed the provider to underbid virtually any other provider of in-home services in California in the competition for the right to provide such services. Fred Keeley, a former employee of several agencies providing in-home services, under both medicare and title XX, provided the committee with this insight:

> I think that one of the basic problems with the system as it now exists with respect to the relationship between a title XVIII medicare provider and a title XX provider is that you can get into a relationship where there is absolutely no incentive to make the client/patient any healthier. In fact, it is absolutely contrary, and that if this is a health care team, we ought to talk about maintaining people's health or making them better, but not to put them on a merry-go-round of federally and State funded programs. That is precisely what you have with the homemaker chore program in their relationship to home health agencies.
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> Aged, blind, and disabled persons may not be in need of medical service. They need a social service at that point. There is no incentive to make them any better if you have a home health agency sitting in the wings which is also a profit-making corporation. Instead of getting $3.50 for providing service, you might be able to get $18 and $20 for that person. You put them on that program, you then use up their benefits under medicare A and B plans, get them back on the social service program and they never get out of the system.
>
> You have people that are supposed to be providing health care. They put helpless persons on a merry-go-round and never let them off. That is not health, that is something else.[83]

Hearings on March 9, 1977, also pointed up shortcomings in the title XX program. Title XX is a program of grants to the States for the purpose of providing social services to the needy. Some 10 percent or $340 million a year in these funds goes to the purchases of homemaker or other in-home services. In this example the provider was certified as a home health agency in the medicaid program in January 1967. By April, the operator was under investigation for altering prescriptions, and excessive billing.[84] In September 1967, the operator

[83] Hearing cited in footnote 82, p. 876.
[84] "Medicare and Medicaid Frauds," part 9, Washington, D.C., Mar. 9, 1977.

was suspended from the medicaid program. He then began to provide services exclusively through the medicare program.

Beginning in May of 1969, the operator was under investigation by medicare authorities. In February, the corporation under which he provided home health services to medicare patients was referred to the Justice Department for prosecution. Shortly thereafter the provider formed another corporation for the purpose of providing similar in-home services under title XX.

In May of 1975, the Bureau of Health Insurance which administers medicare sent a letter to the Justice Department urging prosecution of this provider pointing out that he owed the government $804,000 in moneys fraudulently obtained or inappropriately claimed. In August of that year, the State Department of Health and the California Legislative Audit Committee conducted audits of the providers' services under title XX. They learned that he had charged the program for a significant amount in personal expenses includiug liquor, pipe tobacco, men's clothes, trips to Hawaii, and President Nixon's inaugural. A May 1976 audit by HEW disclosed the same pattern.

HEW found that the provider was mistaken in reporting that his profit on title XX contracts was only 12 cents per hour. HEW placed his profit as more like $1. 05 per hour. HEW disclosed that the operator had charged the program for the payment of his Federal income taxes and for some $4,000 in tax penalties.

The hearings and reports of the Senate Committee on Aging were evaluated by the House Ways and Means and Senate Finance Committee. They incorporated several recommendations and credited the Senate Committee on Aging for its work. (See chapter V on nursing homes which relates to action by the Senate Committee on Aging with respect to fraud and abuse allegedly perpetrated by long-term care facilities and the committee's suggested reforms which were enacted into law.)

The Medicare-Medicaid Anti-Fraud and Abuse Amendments

On October 25, 1977, the President signed into law H.R. 3/S. 143, the Medicare-Medicaid Anti-Fraud and Abuse Amendments. This legislation, which became Public Law 95–142, is designed to facilitate Federal and State efforts to identify and prosecute cases of fraudulent and abusive activities and to strengthen penalties for persons convicted of program-related violations.

Enactment of legislation follows several years of effort. The Committee on Aging cooperated closely with the Senate Finance Committee and with the House Ways and Means Committee to bring about these reforms.[85]

Earlier hearings by the committee provided the impetus for the enactment of Public Law 94–505, establishing the Office of Inspector General in the Department of Health, Education, and Welfare. One provision in the law required the Inspector General to establish within his office a specific unit designed to monitor fraud and abuse in the medicare and medicaid programs.

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[85] See p. 91 for comment by Senator Talmadge.

MAJOR PROVISIONS OF THE FRAUD AND ABUSE BILL

Following are the major provisions of the reform legislation:

(1) Outlaws "factoring" arrangements, i.e., the reassigning of accounts receivable from medicare or medicaid by providers to other organizations or groups for payment.

(2) Requires health care providers with a 5 percent or greater interest in a hospital, nursing home, home health agency, etc., to disclose such interest to the State as a precondition of participation, certification, and recertification in the medicare and medicaid programs.

(3) Strengthens penalty provisions for those defrauding medicare and medicaid, from misdemeanors to felonies. Fraudulent acts such as submitting false claims, offering or accepting kickbacks would be punishable by a maximum of 5 years in jail, a $25,000 fine, or both.

(4) Makes it a felony for nursing home owners to force relatives to make a contribution as a condition of accepting a patient for admission.

(5) Extends the authority of professional standards review organizations who choose to do so to review the medical necessity and quality of care given in shared health facilities, clinics serving the poor otherwise known as "medicaid mills".

(6) Authorizes the Comptroller General, U.S. General Accounting Office, to issue subpoenas in conjunction with any audit or investigation GAO conducts with respect to any program authorized under the Social Security Act.

(7) Requires the Secretary of HEW to suspend from medicare or medicaid participation, for such period as he deems appropriate, a physician or other individual who has been convicted of a criminal offense related to his involvement in either program.

(8) Provides for direct access to records or persons or institutions participating in the medicaid program in the same manner provided to State medicaid agencies.

(9) Allows the States to send medicaid patients explanation of benefits forms, to inform them that a provider is charging medicaid for services allegedly offered on their behalf.

(10) Authorizes the Secretary of HEW to assign and reassign providers to available intermediaries under medicare part A and to designate a regional or national intermediary to perform the functions with respect to a class of providers (such as home health agencies) if in the Secretary's judgment the result would be a more effective and efficient administration of the program. The bill also authorizes the Secretary to have access to all data, information and claims processing operations.

(11) A provider of services under the medicare program is required to promptly notify the Secretary of its employment of any individual who at any time during the preceding year was employed in a managerial, accounting, auditing or similar capacity by a fiscal intermediary or carrier who serves that provider.

(12) Provides 90 percent Federal matching in fiscal years 1978 through 1980 for the costs incurred in the establishment and operation of State fraud control units.

(13) Requires the Secretary to establish uniform reporting systems for each different type of health facility to provide for uniform reporting of costs, volume of services, rates, capital assets, etc. These uniform reporting systems must be in effect within a year following

enactment (with limited exceptions for home health agencies which will have two years before they need comply with the uniform system of accounts to be promulgated).

(14) Requires that all nursing homes maintain a system for the proper handling of patient funds as a condition of participating in the medicare and medicaid programs.

FINDINGS AND RECOMMENDATIONS

Health care costs, particularly the costs of institutional nursing care, continue to rise at a pace faster than general increases in the cost of living. This trend has a major impact on our Nation's elderly population. Efforts to reduce rises in health care costs of all forms will be beneficial to all older Americans. The Committee on Aging, therefore, supports efforts to limit hospital and other health care cost rises with adequate protections for older Americans. Assurances are needed that cost containment measures will not work as a disincentive to the development of nontraditional ambulatory and home care services and that adequate protections will be provided against "dumping" higher-risk patients from acute-care hospitals.

The committee also recognizes that a continued and vigorous thrust by both Congress and the administration against fraud and abuse in the medicare and medicaid programs will result in significant cost savings. The committee urges the Department of Health, Education, and Welfare to continue and intensify its efforts in this area.

The committee further recommends a concerted Federal effort to provide a wide range of community based services as "alternatives" to costly institutional health care for older Americans. Experience to date provides evidence of both less costly and more appropriate maintenance and rehabilitative care which can be provided in alternative settings. An early Federal commitment to this approach becomes imperative when projected increases in the population in need of such care are considered.

The committee recommends:

—Amending the Older Americans Act to provide increased emphasis on development of alternative community systems of long-term care, including comprehensive long-term care centers, adult day health facilities, expanded availability of supportive and maintenance in-home services such as homemaker/home health aide services, and other forms of ambulatory and in-home support.

—Amending title XVIII of the Social Security Act to provide for expanded medicare coverage of home health and homemaker/home health aide services.

—Amending the Health Planning and Resources Development Act to encourage more emphasis on development of alternative community long-term care resources by health systems agencies.

—The committee further urges the Department of Health, Education, and Welfare to develop and recommend to Congress uniform Federal minimum standards for all forms of in-home service now financed by titles XVIII, XIX, and XX of the Social Security Act.

CHAPTER V

ISSUES IN LONG-TERM CARE

During 1977, public concern about apparent widespread fraud and abuse among nursing homes increased as the result of hearings by the Senate Committee on Aging and other congressional units. In addition, the U.S. General Accounting Office released three reports prepared for the Senate Committee on Aging, and the AFL–CIO also released a report critical of nursing home operations. These actions and others helped make the case for several amendments which were added to the Medicare-Medicaid Anti-Fraud and Abuse bill in order to deal with several frequently cited abuses. Also in 1977, nursing homes fought and won a major battle over their entitlement to cost-related reimbursement in the medicaid program.

I. INCREASED PAYMENTS TO NURSING HOMES

Between 1960 and 1976, total revenues for nursing homes increased 2,000 percent, from $500 million to more than $10.5 billion. By fiscal 1977, total payments to nursing homes from all sources had reached $12 billion. They will reach $14 billion this year and if current projections hold, the total will be some $15.50 billion next year. As compared from 1960 through 1979, nursing home revenues will have increased 3,000 percent.

The medicaid program, which provides assistance to the poor and the indigent elderly, will continue to account for roughly 50 percent of total industry revenues. Medicaid's contribution (which is 56 percent Federal funds and 44 percent State funds) will be a $6.1 billion in 1977, at $6.9 billion this year and is projected at $7.6 billion in the fiscal year 1979 budget.[1]

Payments to nursing homes will continue to be the largest single category of medicaid payments, accounting for 38 percent of all such expenditures. Outlays for hospital care ranked second, with 31 percent of the total.

Medicare's contribution by contrast, will continue to be small. In 1977, medicare paid $362 million to nursing homes on behalf of beneficiaries. This amount will increase to $406 million this year and to $469 million in the President's fiscal year 1979 budget.

The percentage of medicare moneys going for nursing home care has been declining slightly. Such payments made up 3 percent of the medicare budget in 1975 but will account for only 2.29 percent of medicare payments in fiscal year 1978. Measured in terms of total industry revenues, medicare will contribute about 5 percent of the total.

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[1] Statistics in this section derived from the President's proposed 1979 budget and from Charles Lawhorn, Budget Section, Department of Health, Education, and Welfare.

Private contributions continued to be an important source of nursing home payments in 1977, accounting for about 45 percent of total payments, a level that will be continued this year and in fiscal year 1979.

II. AUDITS BY THE GENERAL ACCOUNTING OFFICE

Acting on requests by Senator Frank E. Moss, while Chairman of the Subcommittee on Long-Term Care of the Senate Committee on Aging, the U.S. General Accounting Office completed and released three audits in 1977. One was a review of Federal and State audit controls; the second, an examination of the issue of forced contributions; and the third, a financial audit of Kane Hospital, the second largest nursing home in the United States.

A. Audit Controls Lacking

In an audit of Florida, Massachusetts, New York, and Virginia, released by Committee on Aging Chairman Frank Church (in his March 1977 testimony before the House Interstate and Foreign Commerce and House Ways and Means Committees), GAO documented common financial abuses perpetrated by some nursing homes participating in the medicaid program.[2] These abuses included:

—Charging medicaid for services unrelated to patient care.
—Failure to offset costs with related income.
—Unsupportable or "paper" costs primarily involving non-arms-length transactions between related parties.
—Excessive salaries and unsupportable costs, such as travel, long-distance telephone calls, and promotion expenses.
—Charging medicaid for the costs of repairs which should have been capitalized.
—Misuse of patients personal funds.
—Charging medicaid for luxury automobiles and boat expenses and depreciation not related to patient care.
—Misreporting of total patients' days (for which the facility was eligible to be reimbursed).

GAO concluded that in-depth field audits were the only means possible of discerning such abuses. It concluded that while such audits require an initial investment, the results in terms of medicaid dollars saved more than justifies the initial expense.

GAO also concluded that HEW had not given the States appropriate guidance on the importance of such filed audits. However, GAO notes that HEW had published regulations requiring that the States audit all homes at least every 3 years beginning no later than January 1978. GAO described procedures by the States to recover overpayments as weak. GAO recommended that HEW assess State action to comply with recent regulations requiring States to identify and report overpayments to nursing homes "on a timely basis" and to deny Federal participation in overpayments when States do not establish effective, prompt recovery programs.

The audit discussed State, county, or municipally owned facilities. Such facilities have not been regulated or audited with the vigor of

[2] "State Audits to identify Medicaid Overpayments to Nursing Homes," U.S. General Accounting Office, Jan. 24, 1977.

for-profit facilities, according to GAO, because the State (or the city) is both the owner and the regulator. The audit names a municipal facility in Massachusetts which reported costs of $1.1 million in 1973. GAO reports that fully 20 percent, or $223,000, of charges passed along to medicaid were not appropriate. GAO found that the city had charged the facility with a $123,000 real estate tax which was not paid by the facility but passed along to medicaid as a cost of providing care to medicaid patients. A similar "paper" cost on the home's books was $16,000 in "interest" expenses, which was not paid by the facility but reported to medicaid as a cost of providing care to patients.

In New York, GAO found similar problems with a county facility whose costs, submitted to medicaid in 1973, were $14.2 million. GAO disallowed more than $250,000 of this total.

B. Forced Contributions

On May 26, 1977, GAO presented to Senator Church its study of the practice of some nursing homes to require relatives to make contributions as a precondition for admitting patients to nursing homes.[3] The audit was conducted in the States of Florida, Georgia, Ohio, and Utah. GAO concluded:

> The issue of contributions by medicaid patients' families is difficult to deal with because of the lack of Federal laws or regulations specifying what nursing homes may or may not do in soliciting contributions.
>
> State laws and policies in the four States we reviewed do not prohibit the solicitation of contributions, but one, Florida, has recently enacted legislation prohibiting such solicitations through coercion or as a condition of admission or continued residency in a nursing home.
>
> We believe the lack of Federal guidance may have allowed nursing homes to bring subtle pressures on the families of medicaid patients by:
>
> —taking advantage of the guilt feelings the families might have for placing relatives in nursing facilities rather than keeping them at home, and
>
> —creating fear that nursing home would drop out of the medicaid program, which would result in the removal of medicaid patients.

GAO called upon HEW to issue regulations and to develop a standard form, which patients and their families would sign during admissions, clearly stating the legal issues and the patients families' rights concerning contributions. GAO recommended that the committee initiate action to amend the law to provide for "a clear statutory basis for prosecution in the event contributions are solicited by nursing homes as a precondition for admittance or as a requirement for continued stay."

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[3] "Requiring Contributions from Families as a Precondition of Admitting Patients to Nursing Homes," May 26, 1977.

III. KANE HOSPITAL

On December 9, 1975, the Senate Committee on Aging conducted a hearing with respect to alleged abuses and poor care at Kane Hospital, a 2,200-bed nursing home in Allegheny County, Pa. That hearing was summarized in one question which Senator Charles Percy asked of Father Hugh J. McCormley, Chaplain at Kane Hospital. He asked, "Would you put your mother in Kane Hospital?".

Father McCormley answered:

> My mother is an invalid. She had a stroke 4 years ago and we have been able to maintain her at home. At present, however, we are just running on a shoestring in our situation. We are inches away from making a decision. At times, we felt compelled to make the decision to put her in an institution. The only thing I can say is that I would rather bury my mother than ever put her in an institution, especially Kane.[4]

Following the hearing Senator Moss asked GAO to investigate charges by present and former Kane employees that the facility was deliberately defrauding both the patients and the medicare and medicaid programs. GAO completed its audit, which was released by Senator Church on September 9, 1977.[5]

GAO found that Kane misused patients' funds. Medicaid law requires that each patient receive a $25 monthly stipend to cover incidental, personal expenses such as cigarettes, haircuts and candy. In documenting that these small amounts were not finding their way to patients at Kane, GAO took the opportunity to mention its previous six-State audit on this subject for the committee, released on March 18, 1976.[6] GAO noted that HEW had yet to issue new regulations to protect patients' funds from misuse and misappropriation.[7]

GAO also learned that Kane and Allegheny County had double-billed the medicare and medicaid programs of almost $1 million. GAO said the Federal share of such *overpayment* (emphasis supplied) in 1972–74 was estimated at $655,000. In addition, Kane's recovery of deductible and coinsurance from patients' funds resulted in a duplicate reimbursement of another $601,000 for this same period. In releasing the report, Senator Church commented:

> When it is a public facility involved we call it overbilling. When a private facility or an individual is involved, we call it fraud. I see no logic or reason to such a distinction.[8]

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[4] "Trends in Long-Term Care," part 26, Washington D.C., Dec. 9, hearings by the Senate Committee on Aging. 1975, p. 3462.

[5] "Lack of Coordination between Medicaid and Medicare at John J. Kane Hospital," May 6, 1977, released Sept. 9, 1977.

[6] "Improvements Needed in Managing and Monitoring Patients' Funds Maintained by skilled Nursing and Intermediate Care Facilities," Mar. 18, 1976, reprinted in "Medicare and Medicaid Frauds" hearings by the Senate Committee on Aging, part 6, Washington, D.C. Aug. 31, 1976, p. 697.

[7] Senator Frank Church sent both the Mar. 18, 1976 GAO audit and the Kane Hospital audit to Senator Herman Talmadge, chairman of the Health Subcommittee, Senate Finance Committee, which resulted in amendment incorporated in Public Law 95–142, which makes misappropriation of patients personal funds a felony punishable by up to 5 years in jail, a $100,000 fine, or both.

[8] "Medicare and Medicaid Frauds," part 12, hearings by the Senate Committee on Aging, Washington, D.C., Sept. 9, 1977, not yet in print. At that hearing, newly appointed Kane Hospital Administrator Stephen Lehnhart entered in the record a statement which included a list of improvements which had been instituted at the facility since the committee's December 1975 hearing. He complimented the committee for its interest in Kane's problems and he in turn was complimented by the committee for his efforts to improve the quality of care at the facility.

GAO found that Kane had a policy which encouraged relatives to make donations, and that relatives were not fully advised that such contributions were voluntary. In fact, family members were subsequently sent monthly reminders (invoices) about their promised contributions. None of the relatives GAO interviewed were aware that they were not obligated to make payments; indeed some people said they felt pressure to contribute.

IV. THE AFL–CIO REPORT

On February 25, 1977, the American Federation of Labor-Congress of Industrial Organizations Executive Council released a report entitled, "America's Nursing Homes: Profit in Misery," prepared by the AFL–CIO's departments of community services, social security, legislation, public relations, and organization and field services. The yearlong study was based largely on on-site inspection by union volunteers of 128 nursing homes in 120 communities throughout the United States.

The report describes "serious" and "life threatening" violations "in a number of inspected (by union volunteers) homes" and notes that "the investigation brought forward a number of individuals with serious allegations concerning uninspected homes." Theab uses reported by the AFL–CIO ranged from deaths due to negligence or injury, to bribes, profiteering, unsanitary conditions, to poor food and violations of fire safety codes.

The report also charges that nursing home standards are weak and vague and that they are enforced by inspectors who were poorly trained and informed in the laws and regulations. AFL–CIO asserts that there is no direct Federal enforcement of standards and that State enforcement is haphazard and fragmented. The report charges that "organized lobbies" representing the nursing home profession at the State level have "overwhelmed State legislatures" to the detriment of the aged and infirm.

The report depicts nursing home employees as "generally undercompensated, overworked, inadequately trained for their job responsibilities, offered little opportunity for promotions from within the facility and were highly dependent upon servicing the proprietary interests of management."

The report concludes that "one common thread leads to an inescapable conclusion: Most of the problems in nursing homes can be traced to the profit motive, which is incompatible with social programs."

The report adds:

> This is not to state that there are no problems in nonprofit homes, the most frequent being pressure on relatives to make donations. But the facts are that nonprofit nursing homes spend more on patient care and more on staffing than profit-making institutions, and the results are evidenced in better care for nursing home residents.

The report asserts that physicians have not paid enough attention to the elderly in nursing homes and that there is a general lack of

funds for home health care. It concludes that there has been a general failure to formulate a national policy with respect to long-term care. The AFL-CIO report concludes:

> To the average older American, nursing homes have become almost synonymous with death and protracted suffering before death.

The report offers a number of recommendations:

(1) The neglect or abuse of medicare or medicaid patients resulting in injury or death should be made a Federal offense.

(2) Nursing home owners convicted of neglect leading to injury or of fraud should be barred from participation in medicare and medicaid.

(3) Existing Federal regulations should be clarified, and enforced swiftly and fairly.

(4) Federal funds should be made available for the training of nursing home inspectors.

(5) Access laws for volunteers should be enacted to allow community groups to have access to nursing homes for the purpose of visiting patients.

(6) A Federal law should be enacted prohibiting the giving of advance notice of inspections.

(7) Medical schools and schools of nursing should be given Federal funds to encourage them to establish programs in geriatrics.

(8) There should be a gradual phasing out of private, for-profit nursing homes and replacement by nonprofit, religious, or government ownership.

(9) There should be full disclosure of ownership of nursing homes as a precondition of participating in the medicare or medicaid programs.

(10) HEW should allow hospitals in rural areas where there is a shortage of nursing home beds to use unused hospital beds to house nursing home patients.

(11) There should be forgiveness of Federal loans to medical students who agree to work in long-term care facilities after graduation.

(12) All nursing homes participating in medicare or medicaid should be required to install sprinkling systems as a protection against fire.

(13) Physicians and pharmacy owners should be barred from having financial interests in nursing homes in view of the obvious conflicts of interests inherent in dual financial interests.

(14) Federal support for home health care should be extended but agencies offering such care should be licensed by the Federal Government.

(15) A national rating system for nursing homes should be established in order to aid the consumer in the selection of such facilities.

(16) The patients bill or rights should be enacted by the Congress as a matter of law and thereafter be rigorously enforced. Moreover, a private right to litigation and to money damages should be incorporated so that suits may be brought by and on behalf of nursing home patients directly.

V. REPORT BY NEW YORK'S SPECIAL PROSECUTOR FOR NURSING HOMES

During the last week of December 1977, Charles J. Hynes, deputy attorney general and special prosecutor for nursing homes, released his third annual report.[9] Mr. Hynes had been appointed in 1975, following disclosures of widespread fraud in the nursing home industry in that State. (After hearings by the Senate Committee on Aging in January and February 1975, all subpenaed books and records and investigative memorandums in the committee's possession were turned over to Mr. Hynes.) As of December 31, 1977, Mr. Hynes had:

—Obtained 120 indictments.
—Secured 53 convictions out of 65 completed cases (5 acquittals and 7 dismissals).
—Conducted audits of 136 nursing homes (31 percent of the nursing home beds in the State of New York).
—Identified $28 million in overstated operating costs and instituted civil suits to recover this money.
—Helped the State prepare 33 cases of tax fraud resulting in $3.5 million in liens and assignments in favor of the State of New York.
—Obtained a $6 million grant from HEW to investigate and prosecute abuses in New York hospitals.
—Prepared a report of the "scandalous conditions" in New York's adult care homes (boarding homes).

Prompted in large part by the work of the special prosecutors office, an amendment was added to H.R. 3, the fraud and abuse bill (Public Law 95–142) which will provide 90 percent funding to the States for each of the next 3 years to help them establish similar units.[10] The report of the House Commerce Committee accompanying the bill says in part:

> The committee was particularly impressed with the organization and operation of the New York Special Prosecutor's Office, and believes it constitutes a model for anti-fraud efforts in other States.

Deputy Attorney General Hynes called for the establishment "of a permanent freestanding office in New York State" as the only effective means of controlling medicaid fraud. He said:

> My investigations have graphically illustrated that medicaid is fraught with fraud and abuse. Resolution of this problem demands: that those who defraud medicaid be identified, prosecuted and punished, and that punishment of wrongdoers deter others; that our system of reimbursement reward cost-effective health care and meaningfully penalize unnecessary spending and poor patient treatment; that the procedures by which we administer the medicaid system be simple, fair, and efficient; and finally, that money reimbursed on the basis of fraud and mismanagement be promptly and fully returned.[11]

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[9] "Annual Report 1977," Charles J. Hynes, Deputy Attorney General for Nursing Homes, Health and Social Services, 270 Broadway, New York, N.Y. 10007.
[10] In his Mar. 17, 1977 testimony before the House Ways and Means Committee and the House Interstate and Foreign Commerce Committee, Senator Church suggested Federal funding for State fraud and abuse units. This suggestion was also formalized in a recommendation by the Senate Committee on Aging in its June 1977 report, "Kickbacks Among Medicaid Providers."
[11] Page 61 of report cited in footnote 9.

VI. THE COMMITTEE'S REPORT ON KICKBACKS

On March 7, 1977, Senators Frank Church and Pete V. Domenici, ranking minority member of the committee, sent a position paper to the chairman of the House Ways and Means and Interstate and Foreign Commerce Committees. The House committees were conducting joint hearings on the subject of medicare and medicaid fraud. The paper summarized the evidence the Committee on Aging had collected in the course of its investigations conducted in California, Illinois, New York, Florida, Wisconsin, and Utah. The document was later printed as a Senate report entitled: "Kickbacks Among Medicaid Providers." [12]

The report concludes: "The evidence is overwhelming that many pharmacists are required to pay kickbacks to nursing home owners as a precondition of obtaining a nursing home's business."

The committee report cites: "significant and convincing evidence" that "kickbacks are widespread in medicaid." The report adds that after the committee's indepth analysis in the States mentioned, "there can no longer be any doubt about this pervasive practice which picks the taxpayers pocket." [13]

Among the evidence cited in the report was a description of an undercover investigation conducted by Special Prosecutor Hynes in New York. Cooperating nursing home owners and suppliers wore concealed microphones while negotiating contracts for food services, pharmacy services, and linens. More than 50 conversations were recorded. When asked how widespread the problem was, Mr. Hynes indicated that about half of all the nursing homes in New York were found to indulge in such kickback schemes.[14]

The report recommended that the Federal statute which barred the offering, solicitation, or receipt of kickbacks be upgraded from misdemeanor to felony status.

VII. NURSING HOME REFORMS: PUBLIC LAW 95-142

Citing the work of the Senate Committee on Aging and the Permanent Investigations Subcommittee of the Senate Committee on Governmental Affairs, Senator Herman Talmadge, in 1977, advanced S. 143—the medicare-medicaid anti-fraud and abuse amendments. Committee members Church, Domenici, Chiles, and Percy cosponsored the legislation. In the House of Representatives, the companion bill was introduced by Congressman Dan Rostenkowski, chairman of the Subcommittee on Health, Ways and Means Committee.

The Committee on Aging assisted in terms of (a) testimony of Senator Church before the House committees in joint hearings, (b) the position paper presented by Senators Church and Domenici, (c) testimony before the committee by former Senator Frank E. Moss, (d) submission of the committee's reports, including those prepared by the General Accounting Office for the committee and

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[12] "Kickbacks Among Medicaid Providers," a report of the Special Committee on Aging (Senate Report No. 95-320), June 30, 1977.

[13] Ibid., p. 28.

[14] See testimony of Charles J. Hynes before the Special Committee on Aging, "Medicare andMedicaid Frauds," part 7, Washington, D.C., Nov. 17, 1976, p. 765 and following.

summarized earlier in this chapter, and (e) by cooperating with the House Ways and Means Committee in joint hearings on fraud and abuse in home health care programs (see chapter IV).

As noted in chapter IV the provisions of the fraud and abuse bill were quite broad, extending from strengthening professional standards review organizations to outlawing factoring. However, there were several provisions which related directly to nursing homes:

(1) The Senate Finance Committee added an amendment which requires all nursing homes to maintain a system for the proper handling of patients' funds as a precondition of participating in the medicare and medicaid programs.

(2) In response to the GAO's report prepared for the Senate Committee on Aging with respect to forced contributions, Representative Claude Pepper added a floor amendment to H.R. 3 which makes it a felony for nursing homes to force relatives to make a contribution as a condition of accepting a patient.

(3) The House Ways and Means Committee and the Senate Finance Committee also concurred with the recommendation made in the Senate Committee on Aging report, "Fraud Among Medicaid Providers" and upgraded penalties for fraud, such as offering or receiving kickbacks, from misdemeanor to felony status. Fraudulent acts with respect to the medicare or medicaid program will henceforth be punishable by a maximum 5 years in jail, a $25,000 fine or both.

On Senate passage of this legislation, Senator Herman Talmadge, chairman of the Health Subcommittee of the Senate Finance Committee credited the work of the Senate Committee on Aging. He said:

> Both H.R. 3 and its companion bill, S. 143, reflect in their provisions the extensive time and effort devoted by several committees of the Congress in exposing fraud and abuse in medicare and medicaid. For example, the Senate's Special Committee on Aging has, for years, vigorously and imaginatively exposed the fastbuck artists and the exploiters who prey on our older Americans. That committee has sought, as we on the Finance Committee have, to keep the Federal programs for the poor and the sick and the old from being corrupted and subverted.[15]

VIII. THE BATTLE OVER COST RELATED REIMBURSEMENT

As a part of the Social Security Amendments of 1972, the Congress enacted a provision requiring the States to reimburse all nursing homes participating in the medicaid program on a "reasonable cost related basis" by July 1, 1976.[16] The amendment was targeted at some States which in order to save money were paying nursing homes what were thought to be inadequate, flat payments unrelated to the costs which the nursing homes incurred. The law was enacted despite the warnings of a vocal minority that nursing home rates were already adequate and that forcing all States to move to cost reimbursement would result in sharp increases in medicaid payments to nursing homes. It was the judgment of the Congress that an acceptable level of care required an adequate level of reimbursement to operators, which could only come with cost reimbursement.

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[15] Congressional Record, Sept. 30, 1977, p. S. 16007.
[16] Public Law 92-603, Sec. 249.

The debate did not end with the enactment of the legislation. Officials in the Department of Health, Education, and Welfare continued to debate the issue. In the end, there was no consensus. On July 1, 1976, the date the Congress had set for the law to be totally implemented, HEW issued its first draft regulations. The effect of HEW regulations was (a) to postpone the effective date of the law until January 1978, and (b) to allow the States to continue to use flat rate payments or virtually any other method of reimbursement as long as they could demonstrate some relationship between the payment formula and nursing home costs.

The American Health Care Association brought suit, alleging that HEW could not push back the effective date of the statute and complaining that the effect of HEW's action was to deprive nursing homes of adequate reimbursement as promised by the Congress.

The position of the industry was strengthened by an audit of San Francisco nursing homes which concluded that medicaid rates in the City were too low and that private paying patients were subsidizing the welfare patients as a result.[17]

An audit conducted by Los Angeles County also agreed that private paying patients were subsidizing medicaid patients but added that "the Medi-Cal reimbursement rate is generally sufficient to meet the the costs of providing an acceptable level of care except in the case of the 100-plus bed facilities." [18]

The Fifth Circuit U.S. District Court agreed with the nursing home industry that HEW could not push back the effective date of a statute by regulation, saying the action was illegal. The court ordered HEW to issue regulations requiring all States to institute cost related reimbursement immediately. HEW, accordingly, has asked all the States to enact cost-related reimbursement formulas as soon as possible and most have already complied as of this date.

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[17] "Financial Study of Skilled Nursing Facilities in San Francisco: 1974–1976," Accountants for the Public Interest, San Francisco, Calif., November 1977.

[18] "Los Angeles County Nursing Home Study 1975–1977," prepared by Mark H. Bloodgood, auditor controller, Los Angeles County, fall 1977.

CHAPTER VI

THE NATION'S RURAL ELDERLY

Rural issues affecting older Americans received attention from the Congress, from practitioners in aging,[1] and from the Federal executive branch in 1977 and early in 1978.

High point of legislative accomplishment was enactment of the Rural Health Clinic Services Act (Public Law 95–210) extending medicare and medicaid reimbursement to qualified nurse practitioners and physician extenders in rural areas.

I. SENATE HEARINGS IN SIX STATES

Field hearings in widely varying locales[2] during 1977 continued a series on "The Nation's Rural Elderly" begun by the Senate Special Committee on Aging in 1976.[3]

Additional hearings, and a committee report dealing with "The Nation's Rural Elderly," are expected within the next year. But several themes expressed at the 1977 hearings are listed below, with a sampling of hearing comments made on each point.

TRANSPORTATION AS AN URGENT NEED INTENSIFYING ALL OTHER PROBLEMS

A witness at the Denver hearing (p. 428) told of an elderly man who had to see an ophthalmologist because of a glaucoma condition. The cost for a minibus round trip of 420 miles was about $85, "and that was a very low cost—the question is, how do you serve the most needy when geography dictates this kind of cost?" The witness, Guidotta Bates, later said:

> One of our most important resources for transportation in all of our counties is the individual volunteer using his or her own automobile. In my county, for instance, we do have 70 individual volunteers who transport the elderly . . .

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[1] For example, the Western Gerontological Society, at its 23d annual meeting in Denver, Colo., in March 1977, conducted symposia and other events on the theme of "Growing Older in Rural America." The fall 1977 issue of the WGS publication, "Generations," sums up major points from the Denver discussion in a section called "Rurals 'R' Ready." The National Council on the Aging January-Februray 1978 issue of "Perspective on Aging" devotes several articles to "A Look at Rural Realities."

[2] Hearings bearing that title were conducted in: Denver, Colo., Mar. 23, Senator Frank Church presiding; Flagstaff, Ariz., Nov. 5, and Tucson, Ariz., on Nov. 7, Senator Dennis DeConcini presiding; Terre Haute, Ind., on Nov. 11, Senator Charles Percy presiding; Century, Davisville, and Pensacola, Fla., on Nov. 21, and in Gainesville, Fla., on Nov. 22, Senator Lawton Chiles presiding; and in Champaign, Ill., on Dec. 13, Senator Charles Percy presiding. Extensive testimony on rural issues was taken at hearings on "New Mexico's Senior Citizens" in Roswell, N. Mex., on Nov. 18 and in Taos, N. Mex., on Nov. 19, Senator Pete V. Domenici presiding. Several witnesses at hearings on "The Elderly Indian" in Phoenix, Ariz., on Nov. 12 (Senator DeConcini presiding) and in Albuquerque, N. Mex., on Nov. 21 (Senator Domenici presiding) also discussed predominantly rural issues.

[3] The earlier hearings were conducted in Iowa, South Dakota, and Nebraska during August 1976 (Senator Dick Clark presiding). For details and additional discussion of rural issues, see chapter IX, "Developments in Aging: 1976," part 1, annual report of the Senate Special Committee on Aging.

At the Tucson, Ariz., hearing, the director of the Senior Now Generation Program said that Pima County has been "inundated" with transportation planning moneys, when the actual need is for direct action and services:

> What we need in the rural areas are vehicles where we can begin a system of transportation. We want and need those vehicles, the money for the drivers, the insurance moneys, and full service maintenance moneys of these vehicles. From physical collection of statistical data, we know that if we had a total of six vehicles immediately in the four rural areas, we could provide daily service to and from senior centers, shopping assistance, medical appointments, escort service, and also develop a transportation system to bring people into the metropolitan area, especially for medical and health services.

In Roswell, N. Mex., a witness said that 16 vans in one large district struggle to provide services to isolated rural elderly but are hampered by poor roads and unavailability of replacement vans. She described another difficulty:

> UMTA (Urban Mass Transit Administration) grants available for our program take approximately 1 year to process before purchases can be made. These grants require hours of paperwork to justify the need of the vans, which limits us to provide other services.

At the Taos, N. Mex., hearing, Gene Barela of the district area agency on aging described a formidable transportation barrier:

> As you know, the Rocky Mountains split our seven counties in half. All your roads are oriented north and south, which means that you might have two communities that are very close in distance but are very far in travel time. Because of this, the cost of running vans, of taking people to meals, of providing services to the people increases very rapidly.

THE NEED FOR GREATER FLEXIBILITY IN OLDER AMERICANS ACT ALLOCATION FORMULAS FOR RURAL AREAS

Colorado Governor Lamm, in a statement for the Denver hearing, said that his State allocates Older Americans Act title III funds on a formula incorporating four weighted factors: the total 60-plus population by planning and service area (weight 55); the total minority elderly population by area (weight 13); the total low-income elderly population by area (weight 19); and the total rural area population by area (weight 13).

He added:

> We do not feel that intervention at the Federal level regarding any formula adjustment is appropriate. Responsibility to allocate the Federal funds should remain at the State level where unique needs of each State can be appropriately addressed.

Another view was given by an area agency director at the Flagstaff, Ariz., hearing:

> Over the past several years, Federal legislation has begun to recognize the greater need in rural areas, but there has been no type of rural factor or indicator allowed for these differences when funding allocation is on a per capita basis. While it is understood that no funding allocation formula can assure scarce population areas the same amount of money received by the dense population areas, at the very least a formula that could take into account the rural factors that result in higher service costs per capita would work for a more reasonable distribution of funds available than now exist.

At the Roswell, N. Mex., hearing, State Commission on Aging Planning Director William F. Vigil said:

> In predominantly rural States, such as New Mexico, social services are scarce and agencies supplying even the most essential services are often nonexistent. Resources are scarce and per capita income is low. The local tax base has difficulty in supporting the most essential services such as water and sewers. . . . It is not uncommon for older persons to travel 80 to 90 miles to the nearest doctor and to all other social services. . . . Our concern with the present formula as it applies to New Mexico, Senator, is that it does not take into account the geographical problems in States with a fairly large area and a number of sparsely settled communities. The needs of the rural elderly population are as severe as those in our urban centers. The rural elderly are often socially isolated because of geographic conditions. We feel very strongly that these elderly citizens should not be penalized by geography.

MEANS OF PROVIDING HEALTH SERVICES IN VAST, SPARSELY SETTLED AREAS

Ed Dunn, director of the Northern Arizona Council of Governments Area Agency on Aging—serving a four-county area larger than the State of Pennsylvania—said at the Flagstaff hearing:

> Medicare, for example, is supposed to serve all older participants fairly. Older persons do pay out the same premiums, deductible, and coinsurance rates, but do they receive equal benefits in return? How can they if they don't have access to a doctor or even a hospital? How can they if there is no way to get them to the treatment or to get the treatment to them? In many communities in northern Arizona there are no medical facilities, no doctors, no dentists. There are limited nursing home facilities, no elderly day care facilities, and a very meager effort at provision of adult social services under title XX of the Social Security Act.

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In Florida, urban bases for rural health services were described at two hearings. At the Pensacola hearing, Warren M. Briggs told of plans of a health care foundation associated with a private Baptist Hospital to provide outreach and other specialized medical services. He said:

> It is a lot less expensive for one doctor and one technician and one nurse to go to Warrington, Blountstown, Atmore, or other outlying areas and provide those specialized services there to 25 or 50 people than it is to bring all of these people to Pensacola or to other big medical centers.

In Gainesville, Richard Reynolds, M.D., chairman of the Department of Community Health and Family Medicine at the University of Florida, said that his department has, for more than 9 years, provided ambulatory health care to citizens in rural counties west of Gainesville. He added:

> Presently our clinics are the major source of health care in one rural county; the only source in two counties. Amalgams of medical students; physicians assistants; assistant students; graduate physicians' assistants; residents in family medicine, pediatrics, and internal medicine; medical school faculty; clinical nurses; public health nurses; and other health professionals provide comprehensive, ambulatory health services to these rural citizens. Over 30,000 patient visits are recorded annually in those communities and an additional 20,000 in Gainesville.

PRESENT AND FUTURE IMPORTANCE OF SENIOR CENTERS IN RURAL AREAS

Maurice Endwright, director of the Indiana State Commission on Aging, described (at the Terre Haute hearing) senior centers as "lifesavers to the rural elderly." He asked for changes in Older Americans Act title V regulations to permit the use of funds for center operations.

At the same hearing, Louise Johnson, former university extension agent for the area and now vice president of the State advisory council on aging, gave this account:

> We have had experience at Greencastle in Putnam County at our senior center and we have several examples of isolated people. One lady was just sitting with something over her shoulder to keep her warm, her thermostat was turned down. She had used all of her money and had bought a little home and she was just sitting there. We did have the nutrition site at our center and we were able to get her to come because she happened to know the director for the nutrition program and she has worked for about 3 years now and that was the thing that she had to look forward to day after day. She was not physically able to do heavy work but she would set the table and put the flatware on the table and this sort of thing, and it has enriched her life tremendously.

Sharon Lindsay, director of the Champaign County Office on Aging, said at the Illinois hearing:

> One method of providing coordination of services for the rural elderly is through multipurpose senior centers. Title V is a welcome funding source to help initiate such centers. There are two problems, however. In some communities, there simply is no suitable structure to be purchased or renovated for a center. Funding for new construction where there is no feasible alternative is needed. Also, after the center is developed, there will be an ongoing need for funding for staff and operating costs. In our State it is unclear what funding units can and should be responsible for local funding.

FRAGMENTATION OF PROGRAMS SERVING THE ELDERLY, AND THE INTENSE IMPACT IN RURAL AREAS

Charles Rupp, director of Community Services, Inc., in Grand Junction, Colo. (pp. 474–5, Denver hearing), provided this inventory of programs with which he deals:

> In order to attempt to deliver needed services to the elderly of western Colorado, Community Services, Inc., has found it necessary to work with and be responsible to an incredible maze of government programs and agencies. Two RSVP programs and one foster grandparent program receive their funding from ACTION; two title VII nutrition programs from the Administration on Aging, coordinated through the Colorado State Division on Aging; one outreach program receives funds through the Community Services Administration; an Areawide information and referral program through title III funds, administered through the Rocky Mountain Area Agency on Aging; nursing home services are provided through private contracts as well as State contracts; and transportation services through funds from most of the above programs, community donations and the Department of Transportation. Services not provided by this agency, but necessary to the clients we serve, are provided by the county departments of social services, mental health, public health, the Department of Agriculture (for food stamps and commodities), and, need I say more—the list is endless.
>
> There is a great need in this country, and this is particularly true in rural areas, for a planned and coordinated delivery system for meeting the needs of the elderly. Presently, we not only have a proliferation of Federal programs for the elderly, we have conflicting eligibility requirements, varying and conflicting guidelines and regulations, and in many cases, duplication of services. Being aware of the geographic distances between communities served here makes these problems mind-boggling. Adding to the confusion, we are becoming increasingly aware of the growing involvement of business and industry in the delivery of services to the elderly, with the incentive being profit. This is to be seen in the

nursing home industry, Meals-on-wheels, and in home and health care programs. If industry is capable of providing these services more effectively and less costly, and does this not seem to be the case, it still needs to be demonstrated that there is a strong commitment to human values and needs.

The majority of those persons working for and with the elderly are dedicated, hard-working, underpaid, and over-extended. Thousands of hours of volunteer time are expended by hundreds of volunteers (Community Services, Inc., has over 1,100 volunteers of all ages, the majority being seniors) but the great lack of resources, generally money, and the bureaucratic restrictions and regulations provide an oftentimes impossible barrier.

IMPORTANCE OF EMPLOYMENT PROGRAMS IN SMALL COMMUNITIES AND FARM AREAS

The Program for Local Service—a Colorado program enlisting 63 paid participants and 800 community volunteers at the time of the Denver hearing—is described in a statement by PLS Director William Hanna (pp. 494–499 of that transcript) as particularly appropriate for rural areas.

At the Taos hearing, Lee Martinez said that the Jicarilla Apache Tribe has committed $80,000 of its own tribal funds to employ the elderly. "So you can see," he added, "that the tribe has a personal commitment to its elderly; however, it is insufficient. They would like for the Federal Government to, likewise, show their sincerity."

In Century, Fla., Mrs. Vera Presley described an employment program which provides work for homemakers, including one who provides 24-hour service in the homes of persons recently discharged from the hospital. The program served 111 persons at the time of the hearing. One man whose wife had died just 3 days before the hearing nevertheless came and testified on what the homemaker service had meant to him and his wife in her final days.

At the Gainesville, Fla., hearing, State Green Thumb Director Marion Campbell said that 633 participants in that program now work in 44 counties—or about 10 to 15 in each county. He added:

> . . . In our most rural counties it is very easy to find 10 or 15 older people needing and willing to work.

He described one such worker:

> Mr. Willie Brown of Olustee, Fla., will be 103 next March and he has been on our program for 3 years. He hardly misses a day, plus he walks about a mile to work. He will fight you for his job.

OFTEN DESPERATE HOUSING NEEDS OF THE RURAL ELDERLY

Among the reasons for persistent, severe housing problems in rural areas suggested (p. 547 of Denver transcript) by Renita Boothe, Western Slope representative for Colorado Housing, Inc., were:

There is a lack of visibility of the problems of housing within rural communities. There are no vast ghettos. There are only dispersed examples of deteriorating and dilapidated houses which are overlooked as isolated examples within the community. Diversity of needs between rural communities, energy impact versus agriculture, are not recognized. There are cases of elderly persons living alone in a tiny, inadequate apartment with too many stairs to climb, but is all that a small, fixed income can buy. Low-cost mobile homes, while providing some advantages, are considered substandard housing according to minimum housing standards and mobile home "hustlers" are rampant. Not an adequate solution.

As we look at the governmental agencies whose job it is to deal with those problems, we see piecemeal and overlapping programs, multiplicity and frequent changes of those programs that have seemed to be designed to discourage rather than encourage the support to the communities for housing programs. Once a community finds a program or combination of programs that will work, the amount of redtape that must be ground out is appalling. Assuming that one can accept the redtape and delays, the tendency of the reviewing agencies to apply urban criteria to rural housing further frustrates communities. According to the 1970 census, close to 60 percent of the Nation's substandard housing was located in rural areas; with only one-third of the population, rural areas account for nearly two-thirds of the housing needs.

A Flagstaff witness, John DeVore, said that only $9,000 for a model home repair program in his four-county area was made available by the Community Service Administration, and added:

> We have run into a situation over in Prescott where the carpenter called to find out how he was going to weatherstrip a blanket that was on the door.

Findings from actual tests conducted in Vigo County, Ind. (and cited at the Terre Haute hearing), showed that weatherization programs can result in significant savings: energy consumption in 108 weatherized homes (64.6 of the units serving older persons) was reduced by 28 to 42 percent.

Rosita Rayborn of Espanola, N. Mex., gave at the Taos hearing this picture of housing need:

> Many live in homes that have had no maintenance since they [the elderly] themselves were able to take care of this. Consequently, roofs are leaking, windows and doors are not sealed properly, and little or no insulation is found in many of these homes. Many senior adults live in below-standard homes; homes without facilities inside—such as bathrooms and running water—are a common sight in the larger area of Taos and Rio Arriba Counties. . . . We go to an 83-year-old person's home and find him in a pool of deep water on his floor and the ceiling about to cave in. . . . It is proof enough of more need for senior citizens low-income housing projects.

FREQUENT INABILITY TO CONTINUE DEMONSTRATION OR OTHER PROJECTS BECAUSE OF LIMITED LOCAL RESOURCES

Edith Sherman, professor at the University of Denver, gave this example:

> There was a program in Colorado called Friendly Telephone Reassurance and Transportation Service in a little mining town in Colorado. It was run by a nurse. She obtained 3 years of funding and when, after 3 years, she got tired and fatigued with her work—all of the volunteer drivers and telephone people got nothing except gasoline costs—when she got tired after 3 years, this program died. Is there a reason, if we have successful demonstration projects, why these programs can't be replicated elsewhere? This particularly might be done in any mountain town, in any agricultural community, with small population and very sizable geographical distances.

Jean Cox, director of an area agency on aging, testified at the Terre Haute hearing:

> Another problem that is not unique just to rural area agencies, but is more acute in rural areas, is the matching requirement on planning, coordination, and pooling of the area agency funding. In small counties, trying to secure the 25-percent match required on the planning portion of the budget and the additional 10 percent on coordination and pooling, we feel we are asking for money in competition with the aging problems we have established here. Since there is so little money available, we feel it unfair to ask for money to maintain the agency when the money is needed so desperately to maintain the programs there for the older people. If all aging programs could be channeled through the State and area units, it would provide more efficient use of personnel and funds and create less confusion to the older people.

II. ADMINISTRATION TESTIMONY

Alex P. Mercure, Assistant Secretary for Rural Development in the U.S. Department of Agriculture, gave this portrait of rural older persons and departmental concerns in testimony presented in March 1978 to House and Senate units considering extension of the Older Americans Act:

> The rural elderly represent more than a third of the Nation's elderly population. Nationally, 1 out of every 10 American is over 65 years of age. In rural areas, that proportion is close to one and five. Approximately 5.4 million persons, or one of every four of those 65 and over, live on farms or in rural communities with populations less than 2,500.

> The inadequate service delivery system for the rural elderly may result in a condition of despair and isolation. Inadequate income, a lack of transportation, home repair, and health care services may prevent the rural elderly from maintaining independence and dignity in their later years.
>
> The most common barriers to the delivery of services in rural areas include: (1) Low population density; (2) higher cost of services; (3) lack of organized communications networks; (4) lack of public or any transportation systems, preventing the elderly from reaching those services which are available; and (5) lack of local moneys to match Federal funds and/or to finance services on a long-term basis.

The Secretary also said that 60 percent of the Nation's substandard housing is in rural areas and that approximately 44 percent of this rural substandard housing is occupied by persons 60 years of age or older. He added:

> Sixty percent of the rural elderly live in homes which were built prior to 1915. Some cannot rely on family members to fix leaky roofs or to replace doors on hinges. The request by the rural elderly for home repair services far exceeds the program assistance presently available.

Other points:

An American Medical Association study reports that there are more than twice as many physicians per 100,000 population in metropolitan areas as in nonmetropolitan areas.

One-third of the rural elderly have incomes below the poverty level as compared to 25 percent in the central city and 17 percent in the suburbs. The Secretary added:

> Nearly 60 percent of the rural elderly who are members of minority groups live below the poverty levels.

As to Older Americans Act issues, the Secretary said:

> . . . 216 area agencies on aging (39 percent) under that act serve rural areas and that the Department of Agriculture welcomes the opportunity provided by the reauthorization of the act "to examine the establishment and operation of AAA's in rural areas to determine the most effective means of coordinating a viable network of services to the rural elderly.

The Secretary also praised the title VII group meals program, adding:

> Additional effort is needed to make the programs more accessible to those who reside in rural areas. The meals-on-wheels program is particularly beneficial to the elderly in nonmetropolitan areas.

The title V program for multipurpose senior centers and other programs administered by the Department of Housing and Urban Development "can provide a focal point for aging services in rural and other communities." He added:

However, based on evidence that we have analyzed, in some rural areas there are no multipurpose senior centers.

In a call for concerted effort to increase the participation of the rural elderly, he said:

> We would hope that in the reauthorization of the act the Congress and the administration could work together to insure that the needs of the rural elderly would be taken into account in order to provide for a more efficient service delivery system.

He also referred to actions taken in the Department of Agriculture to focus attention on the rural elderly:

> Under section 603 of the Rural Development Act, the Secretary has been given a mission of coordinating efforts by other executive branch efforts in enhancing service delivery for rural persons. We have created a staff position within the Policy Coordination and Training Unit of the Farmers Home Administration to work with other agencies and the Congress in planning strategies to more effectively respond to the needs of the rural elderly.

The Economic Context

What were described as alarming trends in the overall economic circumstances of rural America were described at another hearing [4] by John C. White, Deputy Secretary of Agriculture:

> . . . we know in spite of an overall reversal in the tendency of rural people leaving for the cities, many rural counties are continuing to lose population.
>
> In spite of employment growing faster in rural areas, job opportunities are more limited and wages are lower.
>
> Even though median family incomes are rising faster in rural areas than in urban areas, rural families still make $3,000 less than their urban counterparts.
>
> Even though rural, we know poverty is declining, there is a 50-percent higher rate of poverty in rural areas than in urban cities.
>
> Even though rural areas account for only one-third of the Nation's houses, 51 percent of the substandard housing of America is in rural areas.
>
> Frankly, Mr. Chairman, we need to find out the reasons for these alarming facts. We don't know now who is being bypassed in rural development programs, what the unmet needs are, where they are, how they vary by region, what community services are the most deficient, what private industry is doing in rural America—or what it should be doing—or what the quality of the existing services and facilities are, even if we can find out how many services exist. We stand ready to meet this particular challenge.[5]

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[4] "Economic Problems of Rural America," hearing before the Subcommittee on Economic Growth and Stabilization, U.S. Congress Joint Economic Committee, June 7 and 15, 1977.

[5] Page 4 of hearing cited in footnote 4.

Mr. Carter said that the present administration intends to place great emphasis upon his Department's responsibility, as mandated in the Rural Development Act of 1972, for the coordination of all rural development activities throughout the Federal Government. He added:

> We have proposed two broad objectives for rural development. They are to emphasize improved productivity and higher incomes for rural residents, and to target aid to reach higher levels of self-sufficiency—*to achieve better availability of food, housing, sanitation, education, transportation, and medical care for all people, particularly our elderly and low-income citizens.*[6] [Emphasis added.]

Under the heading of "broad possibilities to strengthen rural development," the Secretary said that government loan guarantees, loans with no interest subsidy, and loans with indexed rates could stimulate the flow of private capital into rural areas for purposes including the following:

> This financial aid could be used to increase farm ownership and help more young people enter farming. It could extend home ownership to low income *and our rural elderly who have marginal ability to buy a home.* It could expand and diversify the employment opportunities in rural areas. It could be used for community facilities, or for transportation.[7] [Emphasis added.]

III. THE RURAL HEALTH CLINIC SERVICES ACT

Signed into law on December 13, 1977, the Rural Health Clinic Services Act (Public Law 95–210) is intended to deal with what Senator Dick Clark describes as "a serious obstacle to primary health services in rural, medically underserved areas—those parts of this country that lack an adequate supply of health manpower and basic health services." [8]

He explained:

> Under existing law, medicare and most State medicaid programs fail to pay for services provided by nurse practitioners or physician assistants, unless a supervising physician is present. H.R. 8422 (the Rural Health Clinic Services Act) removes this requirement, while insuring that there is adequate physician supervision of the medical services offered by a rural health clinic.

Senator Robert Dole also welcomed the legislation:

> Rural areas have experienced increasing difficulties in recruiting and retaining physicians. In my own State of Kansas, there are approximately 52 primary care physicians per 100,000 population. Because of statistics such as these, we must continue to emphasize the need for more physicians

[6] Page 4 of hearing cited in footnote 4.
[7] Page 5 of hearing cited in footnote 4.
[8] Page S19233, Congressional Record, Nov. 29, 1977.

> in these areas and support programs such as the National Health Service Corps, but also look to other professionals who are qualified to provide high quality medical and nursing care. Many States have turned to the utilization of nurse practitioners and physician assistants. This legislation is designed to encourage, and not inhibit, as present law does, this utilization. Of course, it is not our intention to supersede any State Nurse Practice Acts, Medical Practice Acts, or laws regulating the practice of physician assistants.[9]

Public Law 95–210 requires general direction of a clinic's professional activities by a doctor but it does not require the physician's physical presence when services are provided.

Other provisions:

—Medicare and medicaid are now authorized to pay for the reasonable costs of services provided by physician assistants and nurse practitioners in rural clinics which meet appropriate standards. States must include provision for such services in their medical assistance plans.

—The Secretary of Health, Education, and Welfare is to conduct a feasibility study of imposing a copayment for each visit to a rural health clinic instead of the medicare deductible and coinsurance.

—The Secretary is also to report to the Congress on the advantages of extending coverage under the medicare program to urban or rural mental health centers.

Regulations published in the Federal Register on March 1, 1978, indicate that rural health clinics may be reimbursed by medicare for the following services:

(1) Physician services and supplies furnished as a part of a physician's professional services.

(2) Services of physician assistants, nurse practitioners, nurse midwives and specialized nurse practitioners, as well as services and supplies furnished as a part of such services.

(3) Visiting nurse services on a part-time basis to homebound patients (limited to areas where there is a shortage of home health agencies.) 42 CFR § 405.2401 et. seq.

The National Senior Citizens Law Center, welcoming the law and the regulations, recently commented:

> Perhaps the most important aspect of the regulations which have been issued thus far is that they require reimbursement for NP or PA services unless States *specifically prohibit* such individuals from engaging in medical practice. This means that where State law is silent on the matter, reimbursement will be permitted, so long as the NP's and PA's meet the education, training, and supervision requirement set forth in the clinic certification regulations. [Emphasis added.]
>
> The Rural Health Clinic Services Act and its accompanying regulations open the door for the growth of primary health care in rural, medically underserved areas.[10]

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[9] Page S19232, Congressional Record, Nov. 29, 1977.

[10] In the Mar. 10, 1978 issue of "NSCLC Washington Weekly."

FINDINGS AND RECOMMENDATIONS

Some progress in meeting the special needs of rural areas was made during 1977, notably passage of the rural health clinics bill. But smaller communities and sparsely populated areas of the country are still underrepresented in many Federal efforts. Nationwide, about 27 percent of persons 60 years or older reside in rural areas, and much more attention and action are needed to overcome the barriers to service posed by isolation and distance.

The Committee on Aging recommends:

—Amending the Older Americans Act (see chapter VIII for additional discussion of Older Americans Act issues) to provide a uniform 90 percent Federal match for all programs under the act administered by area agencies on aging and local planning and service areas. (Currently, the Older Americans Act provides for a 90/10 Federal-local matching share for planning and service areas served by designated area agencies on aging. Planning and service areas without a designated area agency on aging must provide a 25-percent matching share for Federal Older Americans Act funds. Of 612 planning and service areas, 556 are served by area agencies on aging. The remaining 56 areas, in predominantly rural areas, must now provide the higher match even though it is often more difficult for rural areas to meet this requirement.)

—Amending the Older Americans Act to include an expanded program of home-delivered meals. Many rural elderly find it impossible to participate in congregate meal programs because of greater distances and scarce transportation.

—Amending the Older Americans Act to authorize funding for senior center operations. Senior centers are of particular importance to rural older Americans, often serving as the sole source of activities and services.

—Amending the Older Americans Act to increase income limitations for participation in the title IX senior community service employment program up to 125 percent of the poverty level, enabling many more rural elderly to participate in the program.

—Increased funding for rural public transportation, including subsidies for operating expenses.

—Continuation and expansion of the National Health Service Corps, which provides needed health manpower in rural, medically underserved areas, and congressional consideration of further incentives for expansion of rural health clinics and utilization of nurse practitioners and physician extenders in rural areas.

—Special outreach efforts by the Department of Energy to insure that home weatherization programs administered by the Department reach the rural elderly, and increased efforts by the Farmers Home Administration to make home repair grant and loan programs easily accessible by older Americans in rural areas.

CHAPTER VII

HOUSING: NEW LEGISLATION, FOCUS ON NEIGHBORHOODS

Enactment of the Housing and Community Development Act of 1977 continued, and somewhat broadened, Federal housing efforts for older Americans.

In addition, the administration's forthcoming urban policy statement * also gives promise of intensified attention to central cities, where high concentrations of elderly persons reside.

But sharply rising fuel bills (see chapter III, the high cost of energy) and sharp increases in property taxes [1] and rents continued to intensify shelter needs of older persons in many parts of the Nation.

The controversial eviction of elderly residents of a San Francisco residential hotel focussed this committee's attention on forces in American cities which cause neighborhoods to deteriorate and even disappear, displacing people, destroying low-cost housing stock, and disrupting networks of social assistance.

Finally, prior hearings and a report by the Senate Committee on Aging served as the basis for new "congregate housing" legislation intended to preserve independent living for older persons who might otherwise face institutionalization.

I. DEVELOPMENTS IN FEDERAL PROGRAMS

The Housing and Community Development Act of 1977 [2] contains several sections of primary importance to older Americans. These include:

—A continuation of the section 202 program of long-term loans to nonprofit private sponsors at a $750 million funding level. Additionally, $120 million in section 8 rental assistance subsidies are set aside for use in conjunction with section 202 projects.

—During 1977, the Department of Housing and Urban Development (HUD) awarded $630 million to sponsors for the construction and rehabilitation of about 24,000 units in section 202 projects. Also during the year, the first of the projects to receive funding since the section 202 program was revised in 1974 was completed and occupied in Spokane, Wash.

—The section 8 rent subsidy program, which guarantees that assisted households pay no more than one-quarter of gross income for shelter, was reauthorized at a level of $1.16 billion for fiscal 1978; Congress later appropriated this full amount. Older Americans have benefited more than any other age group from the section 8 program, which became the major Federal mode of

* Issued on Mar. 27, 1978, by President Carter.

[1] See chapter IV, section I, "Housing: the Heavy Burden", in "Developments in Aging: 1976," Part 1 annual report of the Senate Committee on Aging, for additional discussion of rising housing costs for older Americans.

[2] Public Law 95-128. Chapter 8 discusses the community development block grant portions of this bill.

housing assistance in 1974. Through the end of 1976, HUD reports, almost half of all assisted units were for the elderly and handicapped; two-thirds of these apartments were new construction.[3]

—The Farmers Home Administration (FmHA) was given new permission to finance special equipment and facilities in its rural housing program, including congregate facilities for frail elderly tenants.

—Title 8 of the act requires all of the Federal financial regulatory agencies (i.e., the Federal Deposit Insurance Corporation, the Federal Home Loan Bank Board, etc.) to encourage the institutions they serve to meet the "credit needs of its entire community, including low- and moderate-income neighborhoods." Institutional compliance will be regularly assessed by the regulatory agency. These community reinvestment guidelines are designed to police "redlining" practices which, by exempting entire neighborhoods from access to financing, can hasten their decay and demise.

A. HUD Activities

HUD undertook other actions during the year which can lead to better housing and communities for older Americans.[4] The Office of Interstate Land Sales, for example, readied new proposed rules which can provide more information, in easier-to-understand form, to individuals considering the purchase of out-of-State property for a retirement home. And the New Communities Administration continued a research study on the barrier-free planning of new residential villages. Preliminary results indicate that accessibility for the elderly and handicapped can be achieved for only 2 to 3 percent additional development costs. The new community developed on Roosevelt Island, in the East River between Queens and Manhattan, features barrier-free access to all buildings and facilities, minibus transportation, and 284 units of housing for the elderly and handicapped.

Policy changes were also instituted. In December, HUD announced the targeting of $174 million to 23 "hard pressed" cities in a move to achieve better "balance" between the aid received by such cities in comparison to their surrounding suburbs.[5] And in March 1978, the Department issued revised section 202 regulations which decentralize the program's administration to field offices and require greater assurances that approved sponsors have acquired suitable sites.[6]

B. The Housing/Welfare Debate

The shape of the future Federal commitment to housing programs became a subject of debate between HUD and other executive branch agencies during the year. In July, it was reported that the Office of Management and Budget (OMB) had proposed that most subsidized

[3] "The Current State of the Section 8 Housing Programs," Congressional Research Service, 77-67E, Mar. 1, 1977.

[4] A summary of HUD's major actions on aging during 1977 is printed in part 2 of this report. On Sept. 8, 1977, Under Secretary Jay Janis announced the creation of a special task force to improve and simplify regulations for the section 8 program.

[5] Washington Post, Dec. 28, 1977, p. A1.

[6] Federal Register, Mar. 1, 1978, pp. 8492-8498.

housing programs be terminated and their funds be transferred to a reformed welfare system that would provide low-income individuals with money for the purchase of shelter on the private market.[7] Critics of such a policy shift have contended that it would end neighborhood revitalization efforts and would have an inflationary effect on the housing market. Later that month, the Department of Health, Education, and Welfare (HEW) reportedly suggested to the White House that a special "tax" be imposed on welfare recipients living in federally subsidized housing, to equalize their benefits with those of other recipients.[8] Secretary of HEW Califano disavowed this proposal,[9] but the debate over how to best assist lower-income Americans, including elderly SSI recipients, continues within the administration. In January 1978, as development of the Carter Urban Policy continued, Secretary Califano urged that the President place his "primary emphasis on people in distress rather than places in distress." [10]

C. New Analyses of Current Programs

During the year, studies of two current housing programs found them to have problems:

—The GAO evaluated the section 236 program of mortgage insurance and operating subsidies targeted at low- and moderate-income households; the program was created in 1968 but suspended in 1973. The GAO found that "Section 236 has been effective in providing housing for moderate income households during a period when the stock of moderately priced rentals has been shrinking rapidly." [11] GAO recommended that the HUD Secretary design new measures to assure that moderate income households receive a greater portion of Federal assistance in the future. About 20 percent of the 450,000 section 236 units are occupied by elderly households.

—The Center for the Study of Responsive Law issued a sharp critique of HUD's efforts to provide shelter for Indians. Between 1969 and 1976, HUD pledged to build 55,446 units on reservations but constructed only 21,181. The report charged that many of these units were poorly constructed, and that the entire program was bogged down in redtape. HUD agreed that serious difficulties persisted and that revised regulations, as well as better coordination with other Federal agencies sharing responsibility for services to native Americans, were required.[12]

II. PRESSURES ON URBAN NEIGHBORHOODS

In the early morning hours of August 4, 1977, 40 elderly Chinese and Filipino residents of the International Hotel, located at the edge of San Francisco's Chinatown, were evicted by over 330 law enforcement officers as 2,000 demonstrators looked on.

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[7] Washington Post, July 14, 1977, p. A1.
[8] Washington Post, July 27, 1977, p. A1.
[9] Washington Post, July 28, 1977, p. A1.
[10] New York Times, Jan. 25, 1978, p. A1.
[11] "Section 236 Rental Housing—An Evaluation with Lessons for the Future," GAO report No. PAD-78-13, Jan. 10, 1978.
[12] Idaho Statesman, Aug. 21, 1977, p. F1. Committee on Aging field hearings in 1977 developed new information about the housing conditions and needs of older Indians; see chapter VI.

On August 5, Committee on Aging Chairman Frank Church dispatched a staff member to San Francisco to investigate. The committee's findings indicate that central city neighborhoods housing large numbers of older persons are often hard-hit by public or private redevelopment. The effort of the International Hotel's tenants to stave off eviction, and their home's razing for commercial redevelopment, had become a focus of the concerns of many of the one-fifth of San Francisco's population who are 60 and older. The committee investigation also indicated:

—Central city neighborhoods housing large elderly populations, and containing networks of friendships and services, were being destroyed at a rate which exceeds the practical capability for provision of adequate substitutes. The International Hotel situation was but one in a long series which had aroused civic concern; federally backed redevelopment programs appeared to have often worsened the situation.

—Long delays in implementing Federal housing projects approved for Chinatown had generated criticism of the area HUD office.

—The vacancy rate in the city was at a crisis level of 2 percent. Waiting time for older persons wishing to move to subsidized housing was a minimum of 3 years. And substandard and dangerous single room occupancy hotels (SRO's), housing a significant portion of downtown elderly, were being torn down rapidly, causing rents in the remaining units to rise precipitously.

—Foreign investment for commercial redevelopment appeared to be intensifying these difficulties. The U.S. Customs Service was investigating the origins of the funds used to purchase the International Hotel to determine whether they had been brought into the United States in compliance with applicable law.

—Many experts argued that old neighborhoods need not be swept aside. A combining of existing housing programs, preservation legislation, and tax breaks could result in the successful recycling of sound structures into model housing for the elderly, at costs considerably below those of new construction.

New Efforts to Save Neighborhoods

As a result of its inquiry into the International Hotel eviction, Committee on Aging members are considering a further, in-depth look at the relationship of older Americans to their neighborhoods and the means by which these basic building blocks of America's cities can be preserved and strengthened.

Other developments at the Federal level also promise to focus attention on neighborhoods, and provide new help:

—The Senate Subcommittee on Financial Institutions held hearings during 1977 on alternative mortgage instruments. It now appears likely that one of these, the reverse annuity mortgage (RAM) will be approved during 1978 by the Federal Home Loan Bank Board.[13] RAM's will permit older homeowners, who are normally

[13] Congressional Record, Mar. 2, 1978, pp. S2773-74.

unable to secure second mortgages, to convert the equity they have saved in their home into a series of annuity payments.[14]

—A new, congressionally created National Commission on Neighborhoods will hold hearings throughout the Nation in 1978. This Commission will make recommendations to the Congress at the start of 1979 on new mechanisms to promote reinvestment; effective means of community participation in local governance; policies to prevent financial red-lining in declining neighborhoods and real estate speculation in those that are reviving; and policies to make maintenance and rehabilitation of existing structures as economically attractive as their demolition presently is.

—Congress will examine and amend the Uniform Relocation Act during 1978. This law provides rights and compensation to those persons and businesses who are displaced by Federal redevelopment and construction projects.

—HUD is placing greater emphasis on neighborhood rehabilitation and the prevention of the unnecessary uprooting of their residents.

In a speech to the National Association of Realtors, Secretary Harris said:

> We must be concerned about the negative, spillover effects of private revitalization projects which lead to involuntary sale of homes, exploitation of eminent domain powers, eviction without relocation, and misinformation to owners and tenants. . . .
>
> She also described the need for "resettlement services and facilities to long-term residents of the inner city.[15]

A task force within the Secretary's Office is studying, and suggesting revisions of, HUD's relocation policies.

In March 1978, HUD submitted its legislative proposals for fiscal 1979. This package proposes to coordinate existing rehabilitation programs to preserve and revitalize neighborhoods, but early congressional reaction has included criticism of inadequate funding levels for the section 312 rehabilitation program.[16]

The Carter administration's urban policy is scheduled for submission to the Congress in the spring of 1978. However, a continuing debate within the administration has centered on the scope and aims of the policy, and the responsibility for implementing it. It is reported that an urban development bank will be a key part of the policy, designed to attract businesses and jobs to distressed areas; however, it has not yet been decided whether this bank will be operated by HUD or by the Department of Commerce.[17]

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[14] The concept of "reverse mortgages" was discussed before the Committee on Aging by Mr. G. H. Wang of Chicago during April 1977 hearings on rising energy costs (see chapter III). In September 1977, a nonprofit development group headed by Mr. Wang received a commitment of section 202 authority sufficient for 100 units for a buy-and-lease-back rehabilitation program which will be targeted at low-income elderly homeowners in selected Chicago neighborhoods. It would purchase their residences, rehabilitate them, and give them first priority to rent them, with section 8 subsidies also being made available. Certain HUD regulations must be waived before the project can get underway.

[15] New York Times, Nov. 16, 1977, p. D9.

[16] "Housing Affairs Letter," Mar. 10, 1978, p. 2. Information about a new rehabilitation program in the State of Maryland is included in the supplemental material, p. 278.

[17] New York Times, Mar. 13, 1978, p. A15.

III. OTHER DEVELOPMENTS

A. Discontent Over Property Taxes

Inadequate housing stock and real estate speculation often combine to drive up property valuations and property taxes. This can be a severe burden on older homeowners trying to live on fixed incomes and is intensified by other rising costs, particularly fuel.

These conditions have been particularly severe in California, where property taxes in some areas have doubled in less than 10 years. Two older residents of that State have proposed a legislative initiative to limit property taxes to 1 percent of market value, which will appear on the June 1978 ballot after receiving one-and-one-quarter million signatures on supporting petitions. This initiative measure has been criticized for threatening disastrous cuts in government revenues, and for providing two-thirds of its benefits to income-producing properties.[18] State legislators, in response to this popular expression of discontent over property taxes, approved legislation in March 1978 which cuts levies at least 30 percent for homeowners, provides tax credits to renters, and provides additional relief for elderly homeowners.[19]

In New York State, Governor Hugh Carey proposed a new "circuit breaker" property tax relief scheme which would assure that low-income elderly homeowners would pay no more than a fixed, small percentage of their income for property taxes.[20]

B. Congregate Housing Legislation

In March 1978, a bill to assist frail elderly residents of public housing was introduced in the Senate.[21] The Congregate Housing Services Act of 1978 (S. 2691) would provide funding directly from HUD to local housing authorities for meals, housekeeping assistance, and other services which can assist impaired residents to remain in their homes and avoid unnecessary or premature placement in nursing homes. The bill is an outgrowth of Committee on Aging hearings and reports [22] which found that congregate services were required by growing numbers of older Americans. Although the program had been authorized since 1970, only a handful of projects had been established because of a lack of service funds. Hearings are scheduled to be held on S. 2691 in the Senate Housing Subcommittee in April 1978.

FINDINGS AND RECOMMENDATIONS

During 1977, the major Federal housing programs serving older Americans—sections 8 and 202—made modest gains on behalf of the elderly. However, debate continued within the Carter administration as to how best to assist low-income Americans to secure decent shelter, and as to the specifics of an urban policy to revive the Nation's cities.

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[18] New York Times, Mar. 2, 1978, p. 33.
[19] Washington Post, Mar. 3, 1978, p. A4.
[20] New York Times, Jan. 4, 1978, p. 11.
[21] Introduced Mar. 8, 1978, by Senator Harrison Williams; Committee on Aging cosponsors at introduction were Senators Church, Domenici, Brooke, Chiles, DeConcini, and Glenn.
[22] "Adequacy of Federal Response to Housing Needs of Older Americans," Washington, D.C., part 13, Oct. 7, 1975; part 14, Oct. 8, 1975. "Congregate Housing for Older Adults; Assisted Residential Living Combining Shelter and Services," a report prepared for use by the Special Committee on Aging, November 1975.

Housing pressures mounted on older Americans, particularly because of revitalization activities which often displace them and destroy neighborhoods, and due to escalating property taxes beyond the resources of those living on fixed incomes.

The Congress should continue and strengthen its commitment to those Federal housing programs which are successfully providing decent and affordable homes for the elderly. It should also enact S. 2691 to provide congregate services for the growing numbers of frail elderly who otherwise face unnecessary institutionalization.

Congressional attention should also be focused on the Nation's neighborhoods, and on the means by which they can be improved without the massive displacement of present residents. Particular emphasis should be placed on innovative mortgage instruments serving the elderly; expanded home rehabilitation assistance; and amendment of the Uniform Relocation Act.

CHAPTER VIII

THE OLDER AMERICANS ACT: A YEAR OF EXAMINATION

> "In considering what to do about the Older Americans Act, we are required by the current state of affairs to suspend our understanding of the act as it stands and concentrate our attention instead on the real problem. We must examine not simply the individual titles of this act but our whole social performance as it relates to older Americans. New national goals must be affirmed if we are to fulfill the basic commitment we have made to a decent life for all older people." [1]

Varying in urgency and scope, the challenge expressed above is being heard with increasing frequency during 1978 as Congress considers renewal of the Older Americans Act.

On one hand, it is recognized that the programs authorized by the act have met widening challenges since first funds were committed in 1966.

On the other, it is argued that the act deals now only with a small fraction of services needed by a growing population of aged and aging Americans, and that it may be losing, not gaining, in the race with present and future needs.

Typical of recent testimony was this summing-up by the National Council of Senior Citizens:

> As important as this legislation has been in the day-to-day lives of so many older people and as much as it has grown in its capacity to serve people, it has barely scratched the surface of the numerous and diverse needs of the elderly. And, as important as it has been, it has the potential to be even more important in the future. With the aging of America, we are obligated to carefully scrutinize the programs and functions under the act and to make improvements wherever possible.[2]

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[1] From testimony by Robert C. Benedict, then Commissioner Pennsylvania Office for Aging, before the House Select Committee on Aging, Aug. 3, 1977. Mr. Benedict was sworn in on Feb. 16, 1978, as U.S. Commissioner on Aging. A press release issued at that time gives this additional biographical information about Commissioner Benedict:

"Benedict, 37, earned a bachelor of science degree from Eastern Michigan University in 1965, a master of public administration from the University of Michigan in 1969, then went on to earn a certificate as specialist in aging from UM's Institute of Gerontology in 1969.

"Before returning to school to earn his master's degree, he worked as staff associate for human services in the Michigan State Human Resources Council from 1965 to 1967.

"After graduating from the Institute of Gerontology at UM, he remained there until 1972 as director of short-term training and director of the residential institute on aging program.

"From 1972 until he was nominated to be AoA head, he served as director, bureau for the aging and commissioner, office for the aging, in the Pennsylvania Department of Public Welfare."

[2] From statement by William R. Hutton, executive director, NCSC, before the U.S. Senate Committee on Human Resources, Subcommittee on Aging, Feb. 8, 1978, at hearings on "Reauthorization of the Older Americans Act." Washington, D.C.

Another appraisal was given by Harold R. Johnson, codirector, Institue of Gerontology at the University of Michigan and Wayne State University:

> As I have reviewed action and progress under the act over the past 12 years, it has seemed to me that when measured against the years preceding 1965—when attention to the needs and rights of older people was desultory, spotty, and incomplete—progress has been very substantial. But in the context of a growing population of elderly people, surviving in greater numbers in a society which emphasizes the liabilities rather than the assets of old age, we are losing ground in some areas and making only marginal gains in others.[3]

Already renewed or modified six times,[4] the Older Americans Act is now undergoing more scrutiny—at congressional hearings, workshops, audits, conferences, and in departmental evaluations—than ever before.

Among the factors contributing to the intensity of the analyses and occasional debates are:

—The growing commitment of funds to its programs—the current budget calls for more than half a billion dollars.

—Interest in or challenges to the capabilities of a Federal-State-area "network"—as mandated in the 1973 Older Americans Act Amendments—which is required to place heavy emphasis on planning, needs identification, and pooling of resources, including those from other governmental agencies and, where available, private organizations.

—Growing realization of the importance of a group meals program now serving approximately 101,090,720 meals yearly to 2,854,755 persons.

—Intensifying support for senior centers as sites for "one-stop delivery of services."

—Speculation, and in some cases, concern about the plans of the present administration in terms of (1) the role and placement of the Administration on Aging, the agency responsible not only for Older Americans Act programs but more general objectives as the Federal Government's focal point in aging in the overall strategy for delivery of services to Americans of all age groups, and (2) budgetary commitments.

Underlying all the other questions was growing speculation about whether the Congress would, in acting to renew the Older Americans Act before the September 30 deadline, decide on a major overhaul or what one State director on aging called "fine tuning, rather than a tearing-down and restructuring of the Older Americans Act machinery." [5]

Adding to the uncertainty on this last point were reports that the administration considered asking the Congress for a simple 1-year

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[3] Testimony at hearing cited in footnote 1.

[4] Public Law 90-42, enacted July 1, 1967; Public Law 91-69, enacted Dec. 17, 1969; Public Law 92-258, enacted Mar. 22, 1972; Public Law 93-351, enacted July 12, 1974; and Public Law 94-135, enacted Nov. 28, 1975.

[5] Statement by Gerald A. Bloedow, executive secretary, Minnesota Governor's Citizens Council on Aging, at workshop on older American programs sponsored by the U.S. Senate Special Committee on Aging, Oct. 13 and 14, 1977.

extension in 1978 in order to have time to develop and offer more far-reaching proposals for 1979.

Later word on administration plans for extension of the Older Americans Act was provided by Health, Education, and Welfare Secretary Joseph A. Califano, Jr., on March 20 before the Select Education Subcommittee of the House Committee on Education and Labor. He said:

> We realize, of course, that the reauthorization of the Older Americans Act cannot wait. So what we propose is that the act be extended now for 2 years, with some relatively modest changes intended to strengthen the network of services to the aging that now exists. *In the coming months, we intend to work with the Congress early next year with much more extensive legislation—legislation dealing with issues that go beyond those addressed in the Older Americans Act.* (Emphasis added.)

Among the specific steps mentioned by the Secretary, but not incorporated into actual legislation at the time of his testimony, were:

> First, we propose that the Congress add language to title I of the act, clearly calling upon all levels of government to help eliminate the remaining social barriers facing the elderly, and calling on State governments to begin developing new systems of personal advocacy to protect the rights of older people. Under this proposal, the States would be asked, for example, to help train citizens who act as volunteer guardians and "representative payees" for elderly persons—persons who help the elderly manage their affairs. States would also train and assist professionals, volunteers, and family members who work with older people each day in preparing such things as tax relief forms, social security applications, and wills.
>
> Second, we propose that the administration of titles III, V, and VII be consolidated, channeling all funds through the network of State and area agencies on aging, while continuing to award funds to States on a formula basis. This will eliminate mountains of paperwork and save thousands of hours for program administrators.
>
> Third, we propose a separate title for training programs and for the support of multidisciplinary centers of gerontology.
>
> Fourth, we propose that there be a separate title focusing on research and development.
>
> Fifth, we propose that State plans for services to the elderly be required every 3 years, instead of every year—which will yield more savings in paperwork.
>
> Sixth, we propose that Congress clearly establish priority in the act for the needs of low-income and minority elderly persons.
>
> Seventh and finally, we request explicit authority to plan a White House Conference on Aging for 1981.[5a]

[5a] For additional discussion of the proposed White House Conference on Aging, see chapter XI of this report.

I. WHERE DOES THE OLDER AMERICANS ACT STAND NOW?

From the very beginning, the Older Americans Act has set forth sweeping objectives.

Title One, "The Declaration of Objectives for Older Americans," specifies: "It is the joint and several duty and responsibility of the Governments of the United States and of the several States and the political subdivisions to assist our older people to secure equal opportunity to the full and free enjoyment" of 10 objectives [6] which clearly go beyond the scope or funding of any one agency. The Administration on Aging is, therefore, required elsewhere in the law to "provide for the coordination of Federal programs and activities" and to carry on a continuing evaluation of Federal housing programs for the elderly, the setting of standards for the licensing of nursing homes, and overall impact of medicare and medicaid on the well-being of the elderly.

Whether the Administration on Aging has the prestige and power base needed to fulfill such mandates is still a matter of study and some skepticism.[7] But armed with such authority, U.S. Commissioners of Aging have sought recognition as a catalyst for interagency and even interdepartmental cooperation on aging.[8]

The question of whether the Administration on Aging can serve as a genuine focal point on aging for governmental action on aging is raised often during discussions of extension of the Older Americans Act, but much more attention is being paid to issues directly related to the operations of programs more directly under the aegis of the major Older Americans Act titles: Development of comprehensive and coordinated service systems (title III); providing low cost, nutritionally sound meals on a group basis in strategically located centers, while also providing some help for the home-bound elderly (title VII); providing funds for acquiring, altering, or renovating existing facilities to serve as multipurpose senior centers capable of becoming a focal point in communities for development and delivery of social services and nutritional services designed primarily for older persons (title V); providing grants for model projects to improve service delivery (section 308 of title III); and providing support for research and training related to aging, with special support going to multidisciplinary centers of gerontology (title IV).[9]

A large number of Federal, State, and local governmental units have become associated, either wholly or partially, or even tangentially, with the above titles in what is generally described as a "network." [10] In addition, private contracting agencies, including in-

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[6] Public Law 89-73, as amended, section 101.

[7] For example, the National Council on Aging in testimony before the Senate Subcommittee on Aging on Feb. 8, 1978, stated that "as just one small part of the Office of Human Development Services, AoA is hardly in a position to affect programs run by other offices of HEW, let alone influence an array of employment, housing, transportation, and financing programs outside of HEW's sphere. (Even AoA's limited position has been seriously weakened by the administration's decision to delay filling vacant positions.)"

[8] AoA has signed interagency agreements with 23 agencies throughout the Federal bureaucracy, including the Department of Transportation, Office of Education, Legal Services Corporation, Social Security Administration, and Community Services Administration.

[9] Title IX of the Older Americans Act relates to Community Service Employment for Older Americans. It is administered through the Department of Labor and is discussed in chapter II.

[10] An editorial in the March-April 1977 issue of "Perspective on Aging," a magazine published by the National Council on the Aging, offers an even broader description: "The 'aging network' consists no longer of only AOA-funded agencies and institutions; it has expanded far beyond that perimeter to include a vast number of small and large community agencies operating on their own, church groups, union programs, and voluntary institutions that provide myriad services to older Americans. All of them need AOA support and integration; all are significant facets of the network—and, most important, all have impact and make a positive difference in the lives of the older population."

stitutions of higher learning, have also developed a stake in the development of the network and the role of that network in serving the needs and aspirations of older Americans, now and in the future.

A. The Maturing of Title III

Until the 1973 amendments to the Older Americans Act, title III provided formula grant funds to the States, which in turn supported individual social services provided by local agencies. But as specified by the 1973 amendments, States allot most of the title III formula grant funds to area agencies, which arrange with local service organizations to provide needed services to the elderly. The General Accounting Office has described [11] the 1973 amendments as fostering "grassroots" planning for programs on aging.

Thus given a crucial role [12] in the "network", area agencies on aging (AAA's) now number 556, located in 612 planning and service areas designated by the States for the purposes of planning and delivering services to people 60 years or older within their boundaries.[13]

A similar view of the actual and potential importance of area agencies was given by Elias S. Cohen—project director, law, aging, and long-term care project at the Public Interest Law Center of Philadelphia—in the keynote address of the New York State Conference on Aging Services at Albany on September 19, 1977:

> There is virtually nothing that lies outside the scope of concern and interest of the area agency. This is not to say that the area agency necessarily must administer all community mental health services, but it does suggest that the area agency has a clear responsibility to assure that community mental health services are made available to the elderly. The same may properly be said of nursing home services, social services, transportation, and the variety of other area specified under the Older Americans Act.

According to the Older Americans Act (Public Law 89–73) a PSA is any unit of general purpose local government which has a population aged 60 and over of 50,000 or more, or which contains 15 percent or more of the State's population aged 60 and over. Although the designation applies to general purpose local governments, the act allows for exceptions to be made where a State can be designated as one planning

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[11] In a report, page 1: "The 1975 Amendments to the Older Americans Act—Little Effect on Spending for Priority Services," Mar. 6, 1978.

[12] Administration on Aging Deputy Commissioner Donald F. Reilly, in testimony on Feb. 1, 1978, before the Subcommittee on Aging, U.S. Senate Committee on Human Resources, listed the following responsibilities of the area agencies on aging: "Development of the annual area plan, for movement toward a comprehensive, coordinated service delivery system to meet the needs of older persons in the area; funding service provider agencies to fill gaps in priority service areas such as information and referral, legal and other counseling, transportation, home services and home repair, providing training and technical assistance to such agencies and monitoring their performance; persuading other public and private agencies at the area, county, city, and neighborhood level to make greater resource commitments to services for older persons, to make policy changes to better serve older people, and to coordinate with the Area Agency and other service providers so that services for older persons become more comprehensive, more coordinated and more oriented to the special needs of older persons; and advocating for provisions to meet needs of older persons on such issues as tax relief, special housing, medical and mental-health services, and public transportation, to county and city government, councils of governments, and economic development districts."

Commissioner Reilly added: "The planning role, plus the managerial and program development role with regard to service delivery development with AoA funds could take up all of the time of area agencies. The advocacy role is challenging because of the wide range of specialized issues to be dealt with. Persuading other agencies to change policies, change their funding patterns, and to give up some degree of autonomy in order to improve the coordination of services delivery to older persons is perhaps the most difficult role of all, for the area agency, which has a limited number of tools available. Since amounts of money larger than those provided under the Older Americans Act flow through other systems which could benefit older persons more than they do, this latter role is of critical importance."

[13] All information about Older Americans Act operations in this chapter are from the most recent Administrations on Aging quarterly report for 1977.

and service area. This exception [13a] has been made for 11 States and territories with relatively small and elderly populations. These States include Alaska, Delaware, Nevada, New Hampshire, North Dakota, South Dakota, Rhode Island, District of Columbia, Guam, American Samoa, and the Virgin Islands.

Funding for these 556 area agencies, 612 planning and services areas and 56 State or territorial offices on aging was small in relation to the demand during 1977. The fiscal year 1977 appropriations allowed for $151 million for title III—$122 million [14] for area planning and social services, $17 million for State administration and $12 million for model projects. The area planning and social services allocations and State administration funds are allocated to the States on the basis of their population aged 60 and over. Those States with small elderly populations are protected by the title III formula which guarantees that "no State shall be allotted less than one-half of 1 per centum of the sum appropriated for the fiscal year for which the determination is made." Fifteen States had small enough aged populations to be designated as "minimum States" and thus fell under the protective formula. The title III allocations to the States for fiscal year 1977 were:

AUTHORIZED FUNDING LEVELS FOR FISCAL YEAR 1977 FOR TITLE III OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED

[Available for obligation through Sept. 30, 1977]

States	Population, 60 plus, July 1, 1975		Title III	
	Unrounded population	Percent distribution	Area planning and social services	State administration
Total, 56 States	31,953,950	100.00000	$120,780,000	$17,000,000
Alabama	534,897	1.67396	1,939,191	228,521
Alaska	15,784	.04940	603,900	200,000
Arizona	317,967	.99508	1,152,746	200,000
Arkansas	373,967	1.17033	1,355,763	200,000
California	2,930,960	9.17245	10,625,833	1,252,183
Colorado	302,076	.94535	1,093,136	200,000
Connecticut	462,346	1.44691	1,676,166	200,000
Delaware	72,045	.22547	603,900	200,000
District of Columbia	101,987	.31917	603,900	200,000
Florida	1,781,967	5.57667	6,460,267	761,299
Georgia	618,320	1.93503	2,241,626	264,161
Hawaii	87,768	.27467	603,900	200,000
Idaho	115,304	.36084	603,900	200,000
Illinois	1,643,227	5.14248	5,957,282	702,026
Indiana	746,877	2.33735	2,707,692	319,083

[13a] The statutory language gives this description of the grounds for exception: ". . . except that the State may designate as a planning and service area, any region within the State recognized for purposes of area-wide planning which includes one or more such units of general purpose local government when the State determines that the designation of such a regional planning and service area is necessary for, and will enhance the effective administration of the programs authorized by this title, the State may include in any planning and service area designated pursuant to this provision such additional areas adjacent to the unit of general purpose local government or region so designated as the State determines to be necessary for, and will enhance, the effective administration of the programs authorized by this title, and

"(2) the State agency designated pursuant to paragraph (1) shall—

"(A) determine for which planning and service areas an area plan will be developed, in accordance with subsection (c) of this section, and for each such area designate, after consideration of the views offered by the unit or units of general purpose local government in such area, a public or nonprofit private agency or organization as the area agency on aging for such area; and

"(B) provide assurances, satisfactory to the Commissioner that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of social services provided under such plan."

[14] The area planning and social services allocation is reduced by 1 percent each year for Federal program evaluation of title III. Therefore, the amount disbributed among the States during 1977 was $120,788,000.

AUTHORIZED FUNDING LEVELS FOR FISCAL YEAR 1977 FOR TITLE III OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED—Continued

[Available for obligation through Sept. 30, 1977]

States	Population, 60 plus, July 1, 1975		Title III	
	Unrounded population	Percent distribution	Area planning and social services	State administration
Iowa	493,705	1.54505	$1,789,856	$210,923
Kansas	385,756	1.20722	1,398,498	200,000
Kentucky	515,411	1.61298	1,868,549	220,196
Louisiana	492,108	1.54005	1,784,064	210,240
Maine	172,919	.54115	626,893	200,000
Maryland	500,390	1.56597	1,814,091	213,778
Massachusetts	937,247	2.93312	3,397,859	400,415
Michigan	1,172,400	3.66903	4,250,370	500,878
Minnesota	599,802	1.87708	2,174,494	256,250
Mississippi	349,993	1.09530	1,268,845	200,000
Missouri	817,299	2.55774	2,963,002	349,170
Montana	109,043	.34125	603,900	200,000
Nebraska	261,678	.81892	948,674	200,000
Nevada	69,089	.21621	603,900	200,000
New Hampshire	121,665	.38075	603,900	200,000
New Jersey	1,111,025	3.47696	4,027,868	474,650
New Mexico	132,179	.41365	603,900	200,000
New York	2,894,291	9.05769	10,492,838	1,236,511
North Carolina	716,226	2.24143	2,596,574	305,989
North Dakota	103,079	.32259	603,900	200,000
Ohio	1,512,980	4.73488	5,485,099	646,382
Oklahoma	458,882	1.43607	1,663,608	200,000
Oregon	366,503	1.14697	1,328,702	200,000
Pennsylvania	1,971,035	6.16836	7,145,707	842,074
Rhode Island	158,677	.49658	603,900	200,000
South Carolina	336,823	1.05409	1,221,106	200,000
South Dakota	116,704	.36523	603,900	200,000
Tennessee	623,588	1.95152	2,260,729	266,412
Texas	1,639,773	5.13168	5,944,770	700,551
Utah	130,718	.40908	603,900	200,000
Vermont	70,543	.22076	603,900	200,000
Virginia	620,156	1.94078	2,248,287	264,946
Washington	511,741	1.60150	1,855,250	218,629
West Virginia	301,514	.94359	1,093,097	200,000
Wisconsin	713,269	2.23218	2,585,858	304,726
Wyoming	49,747	.15568	603,900	200,000
American Samoa	1,100	.00344	301,950	62,500
Guam	3,100	.00970	301,950	62,500
Puerto Rico	294,400	.92133	1,067,310	200,000
Trust Territory	6,400	.02003	301,950	62,500
Virgin Islands	5,500	.01721	301,950	62,500

The area agencies on aging were able to promote or provide an array of services to approximately 11 million people during 1977.[15] In addition, those PSA's without an area agency on aging provided services to 894,780.

The services promoted or provided by the area agencies, as listed by the Administration on Aging:

[15] This figure is reported to be an unduplicated account of the number of persons who participated in the various services provided through the area agencies on aging.

Service	Number served	Title III expenditure
Transportation	2,451,610	$15,999,948
All home services	486,529	16,907,525
Legal and related counseling	198,369	4,029,204
Residential repair and renovation	77,892	4,472,597
Information and referral	3,171,946	8,389,595
Escort	289,754	1,641,594
Outreach	1,430,966	5,700,596
All other services	3,110,001	20,151,678

The emphasis on the four priority services—transportation, home services, legal counseling, and residential repair and renovation—was due at least in part to a statutory requirement that the States provide at least 20 percent of their title III State planning and social services allocation or 50 percent of their increase in allotment of title III funds for these four priority services.[16] The full impact on the priority services provision of title III is still unknown since the requirement has been effective in the programs for only one full funding cycle.

In addition to the services provided through the area agencies on aging, the PSA's without such designated agencies supported 198 projects with $7,177,568 of title III funding.

The annual plan of an area agency on aging must "provide for the establishment of a comprehensive and coordinated system for the delivery of social services within the planning and service area covered by the plan, including determining the need for social services in such area, evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of social services in such area, for the provision of such services to meet such need." [17]

Accordingly, area agencies have become increasingly successful in pooling and tapping existing resources within their assigned areas. During 1977, the area planning and social services allocation under title III of $122 million was reported to have been instrumental in pooling a total of $440,403,806 in cash and in-kind resources. Of this amount, $310,605,601 were Federal resources, $86,563,441 were local resources and $43,234,764 were State resources. Of the $440,403,806 pooled, $226,706,536 were cash resources. The listing of Federal dollars pooled by the area and State agencies included:

[16] Priority services were added by the 1975 amendments to the Older Americans Act, Public Law 94-135, enacted Nov. 28, 1975. The effectiveness of specifying priority services is challenged in the GAO report described in section II of this chapter.

[17] Older Americans Act, Public Law 89-73, section 304(c)(1).

Federal program:	*Dollars pooled*
Title XX of Social Security Act	$77, 135, 326
Medicaid	33, 314, 309
Comprehensive Training and Employment Act (CETA)	25, 647, 605
HUD programs (excluding community development)	22, 780, 041
General revenue sharing	13, 401, 457
Title XX nutrition programs	11, 487, 559
Public Health Service programs	11, 366, 978
Title IX of Older Americans Act	11, 177, 753
Community Development Act	11, 113, 706
ACTION programs	10, 640, 819
USDA commodities	9, 297, 328
Food stamp program	5, 156, 645
Capital assistance grants (DOT)	4, 966, 150
Economic Opportunity Act (senior opportunity and services)	4, 212, 354
Legal Services Corporation	2, 514, 842
Economic Opportunity Act	2, 297, 592
DOT programs	1, 696, 571
Rehabilitation Service Act programs	1, 626, 711
Federal Energy Administration	1, 518, 729
Law enforcement assistance programs	690, 615
Economic Opportunity Act—community food and nutrition	648, 912
Other Federal programs	47, 913, 599

The effectiveness of the area agencies in pooling and securing other dollars for older American benefits varied from State to State and from area to area. But many area agency and State directors agree that their administrative pooling and coordinating has become more effective in stimulating other Federal, State, and local programs to serve the elderly. For example, the president of the National Association of Area Agencies on Aging cited this comment from the director of the area agency in Fairmont, W. Va.:

> Although current allocations of title III funds in West Virginia are relatively small, nevertheless, these moneys are the very cornerstone for most of our county programs which have used these funds very carefully to develop multipurpose programs utilizing a wide range of additional local, State, and Federal funds. We are forced into a position of not being able to show large amounts of services being provided by title III due to the fact that we have used these funds primarily as a launching pad for efforts to develop expanded local support and pool other resources for direct services.[18]

[18] Testimony by Leon Harper, president, National Association of Area Agencies on Aging; and director of the Los Angeles County Area Agency on Aging, at hearing cited in footnote 2.

1. WESTAT STUDY

The Administration on Aging contracted with Westat, Inc., in 1974 to conduct a longitudinal study of two samples of area agencies on aging. The preliminary findings of the first year's studies have been collected and are being analyzed by AoA. In testimony before the Senate Subcommittee on Aging, the Administration on Aging stressed: "These are not the final answers on the performance of the area agencies. They are indicators of early performance." [19] Final data will not be available for several years.

But the first phase of the Westat study had a sampling of 39 area agencies, 1,200 service providers, 37 advisory councils, 19 umbrella agencies, 27 State agencies, and 425 "influential individuals." The data was taken during 1974–76 and therefore can trace only the early developmental stages of many area agencies. In fact, Westat found that 64 percent of the area agencies studied were new organizations which had been in existence for 1 year or less.

Preliminary Westat findings include:

—There has been an overall improvement in the delivery of services to the elderly during the period of the Westat evaluation. Area agencies contributed to about 20 percent of these improvements in the possible areas of change in services to older persons (comprehensiveness, coordination, planning, etc.)

—Approximately two-thirds of the service providers indicated an increase in their volume of services for the elderly as well as their expenditures for elderly services.

—Service providers reported a 26 percent increase in the median number of elderly served—to a median of approximately 500 elderly per service provider.

—Service providers increased the variety of services available by 23 percent.

—Area agencies were responsible about 60 percent of the time for these improvements by service providers. The area agencies were credited with the establishment of about 48 percent of the new services and with about 40 percent of the modification of service programs to serve more elderly.

2. MODEL PROJECTS

Section 308 of title III authorizes the Commissioner "to make grants to any public or nonprofit private agency or organization or contracts with any agency or organization within such State for paying part or all of the cost of developing or operating statewide, regional, metropolitan area, county, city, or community model projects which will expand or improve social services or otherwise promote the well-being of older persons."

The fiscal year 1977 appropriations for title III of $151 million included $12 million for model projects. These funds were used for regional and State demonstration projects. The State projects included allotments to each State to support a nursing home ombudsman and a legal services developer within the State aging network.[20]

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[19] By Deputy Commissioner Reilly in statement cited in footnote 12.

[20] For a description of the legal services developer see section VI of chapter X.

Support is also given to: The National Association of State Units on Aging, the National Association of Area Agencies on Aging, the Urban Elderly Coalition, the National Center on Black Aged, the National Indian Council on the Aging, and the Asociacion Nacional Pro Personas Mayores. Each of these organizations has an office and staff in the District of Columbia.

The bulk of the model projects funding is used for individual projects, including:

—Victim assistance and crime prevention for the elderly (New York City Foundation on Aging and New York City Department on Aging).
—The demonstration of bilingual response to the needs of migrant elderly (Sacramento Concilio, Inc.).
—Mobile minimarkets for the elderly (Food Advisory Service of San Francisco).
—Information Dissemination Model of Innovations in Aging, Project IDEA (University of California at San Francisco).
—The elderly and neighborhood preservation (city of New Haven Human Resources Administration).
—The impact of job opportunities for the older worker (Foundation for Applied Research, FAR).
—Evaluative I & R projects of service providers for the low-income elderly (Washington Center for the Study of Services).
—Service management and in-home services for the frail elderly (Philadelphia Corporation for Aging).
—Elderly day care for the moderately impaired with a school of nursing for the severely impaired in a multipurpose senior center (Lockport Senior Citizens Center, Inc. of New York).
—A model competency based program providing volunteer personnel to the aged in public or private centers (Madonna College of Michigan).
—A comprehensive geriatric services development project (Geriatric Authority of Holyoke Development Office).
—Experimental area agencies on aging and health service agency integration project (Urban Health Institute of New Jersey); and
—Special transportation services for the elderly (City of Portland, Oreg., Human Resources).

B. The Nutrition Program for the Elderly—Title VII

> "Title VII, though, is more than just a hot meal program for the elderly. It also provides a place for the elderly to meet and talk with others. In some cases this socialization function is more important than the meal itself. Title VII project directors have made this point emphatically. They have described the friendships, even marriages, resulting from interaction among participants. Many older Americans have become volunteers, cooks, transportation assistants, and outreach workers after becoming involved with this program." [21]

Title VII encompasses more than 1,047 nutrition projects serving meals at 9,166 congregate sites in every State. Meals were served in

[21] Testimony by Senator Edward M. Kennedy before the Senate Subcommittee on Aging, Human Resources Committee, on "Home-Delivered Meals for the Elderly," May 13, 1977.

senior centers (22 percent), religious facilities (24 percent), schools (4 percent), housing complexes (13 percent), restaurants (2 percent), and other facilities. More than 450,000 meals were being served daily by the end of 1977 to an estimated 2,854,755 persons—67 percent of whom were low-income and 22 percent of whom were minorities. In addition, 127,994 volunteers, more than 100,000 of them elderly, assisted in meal preparation, collection of contributions, meal service, transporting of participants and overall program activities.

During 1977, approximately 85 percent of the meals were served at congregate sites while the remainder were served to homebound elderly. The Administration on Aging estimates that the total cost of each meal was approximately $1.73, while the total program cost per meal was estimated at about $2.46. Cost of meals did not vary considerably between those catered (64 percent) and those prepared on site (36 percent).

Title VII operated at a level of $225 million during fiscal year 1977.[22] These funds were distributed to the States and territories in accordance with their 60 and over population.

FISCAL YEAR 1977 STATE ALLOTMENT AMOUNTS UNDER TITLE VII OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED

[Available for obligation through Sept. 30, 1977]

States	Population, 60-plus July 1, 1975		Title VII, nutrition
	Unrounded population	Percent distribution	
Total, 56 States	31,953,950	100.0000	$201,489,750
Alabama	534,897	1.6740	3,234,752
Alaska	15,784	.0494	1,007,448
Arizona	317,967	.9951	1,922,888
Arkansas	373,967	1.1703	2,261,540
California	2,930,960	9.1724	17,724,803
Colorado	302,076	.9453	1,826,790
Connecticut	462,346	1.4469	2,796,002
Delaware	72,045	.2255	1,007,448
District of Columbia	101,987	.3192	1,007,448
Florida	1,781,967	5.5767	10,776,331
Georgia	618,320	1.9350	3,739,243
Hawaii	87,768	.2747	1,007,448
Idaho	115,304	.3608	1,007,448
Illinois	1,643,227	5.1425	9,937,304
Indiana	746,877	2.3373	4,516,684
Iowa	493,705	1.5450	2,985,647
Kansas	385,756	1.2072	2,332,826
Kentucky	515,411	1.6130	3,116,915
Louisiana	492,108	1.5400	2,975,985
Maine	172,919	.5411	1,045,716
Maryland	500,390	1.5660	3,026,073
Massachusetts	937,247	2.9331	5,667,947
Michigan	1,172,400	3.6690	7,090,016
Minnesota	599,802	1.8771	3,627,261
Mississippi	349,993	1.0953	2,116,553
Missouri	817,299	2.5577	4,942,565
Montana	109,043	.3412	1,007,448
Nebraska	261,678	.8189	1,582,477
Nevada	69,089	.2162	1,007,448
New Hampshire	121,665	.3807	1,007,448

[22] The appropriations level for fiscal year 1977 was $203.5 million. However, the Congress set a spending level of $225 million because of the existence of carryover funds. The $203.5 million was reduced by 1 percent ($2,035,250) for title VII program evaluation.

FISCAL YEAR 1977 STATE ALLOTMENT AMOUNTS UNDER TITLE VII OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED—Continued

[Available for obligation through Sept. 30, 1977]

States	Population, 60-plus July 1, 1975		Title VII, nutrition
	Unrounded population	Percent distribution	
New Jersey	1,111,025	3 4770	$6,718,861
New Mexico	132,179	.4136	1,007,448
New York	2,894,291	9.0577	17,503,038
North Carolina	716,226	2.2414	4,331,329
North Dakota	103,079	.3226	1,007,448
Ohio	1,512,980	4.7349	9,149,660
Oklahoma	458,882	1.4361	2,775,055
Oregon	366,503	1.1470	2,216,399
Pennsylvania	1,971,035	6.1684	11,919,710
Rhode Island	158,677	.4966	1,007,448
South Carolina	336,823	1.0541	2,036,919
South Dakota	116,704	.3652	1,007,448
Tennessee	623,588	1.9515	3,771,108
Texas	1,639,773	5.1317	9,916,435
Utah	130,718	.4091	1,007,448
Vermont	70,543	.2208	1,007,448
Virginia	620,156	1.9408	3,750,354
Washington	511,741	1.6105	3,094,731
West Virginia	301,514	.9436	1,823,389
Wisconsin	713,269	2.2322	4,313,454
Wyoming	49,747	.1557	1,007,448
American Samoa	1,100	.0034	507,724
Guam	3,100	.0097	507,724
Puerto Rico	294,400	.9213	1,780,374
Trust Territory	6,400	.0200	507,724
Virgin Islands	5,500	.0172	507,724

1. HOME-DELIVERED MEALS

As stated earlier, home-delivered meals are allowed under title VII programs if associated with a congregate site. Approximately 15 percent of the meals served during 1977 were those delivered to the homebound elderly.

Demand for in-home meals fluctuates with the health and well-being of the participants. However, the Administration on Aging estimates that from 9 to 12 percent of the 33 million persons aged 60 and over are homebound and, therefore, likely candidates for meals-on-wheels.

This probable demand was recognized by Senators George McGovern, Edward Kennedy, and Charles Percy, when they introduced bills (S. 519, S. 1283, and S. 2580) which would provide for a separate authorization under title VII for home-delivered meals. The rationalization for a separate authorization under title VII was given by Senator McGovern:

> Presented with one lump sum of money, title VII projects have channeled most of these resources into congregate sites where more people can be fed for less. I think that priority is both understandable and reasonable, but it is also detrimental to the furnishing of services to the homebound . . . the title VII network offers an excellent mechanism for administering a national meals-on-wheels program. To create a new structure would duplicate efforts. It is far easier, more efficient and less expensive to simply change the target popu-

> lation of the title VII program for the rather limited purposes of a meals-on-wheels program than to establish a completely new bureaucracy for all or even a fraction of the homebound.[23]

S. 519, S. 1283, and S. 2580 would provide for authorizations of $80 million for the first year of operation and $100 million for the second. These funds would be allocated to the States on a formula basis, as are title VII funds. The States would then receive an allocation for congregate programs and an allocation for a home-delivered meals program. These funds would be channeled by the States to the local project levels. There the projects could have home-delivered meals programs operating in conjunction with the congregate programs, or have freestanding home-delivered meals programs where conditions warrant such services. The McGovern-Percy bills (S. 519 and S. 2580) would allow for the home-delivered meals program to serve nonelderly disabled persons—up to 15 percent of the participants could be nonelderly. The Kennedy bill (S. 1283) limits participation to older persons.

All three bills recognize the value of coordinating the congregate and home-delivered program in order to provide the best possible care *and* fellowship. The director of Meals-on-Wheel of Central Maryland described the coordination:

> These programs should not be either/or, but work in concert with one another. First to lessen isolation and then to lessen institutionalization. The focus is to provide the highest quality of service for the most reasonable cost.[24]

These proposals are being considered as amendments to the Older Americans Act.

2. COMMODITIES

In addition to its $225 spending level for fiscal year 1977, the title VII nutrition program's budget allowed for $30 million of USDA commodities. These commodities were issued to the nutrition projects on the basis of 27.25 cents per meal served. The dollar amount of commodities per meal is determined on changes in the cost-of-living standards.

The commodities provision has been of great assistance to the States and projects for increasing their number of meals served. However, complaints increased over the last few years regarding the cost of transporting and storing such commodities, the nutritional value of certain commodities, and their value in the diet. Many commodities were foods which could not be chewed and digested by older persons. Some contained spices which are discouraged in certain diets.

In response, Senator Edward Kennedy introduced legislation (S. 1170) which would extend the commodities allowance under title VII and amend the section to allow States the option of receiving the cash value instead of the commodities. This legislation was enacted and signed by the President.[25]

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[23] Testimony by Senator George McGovern at hearing cited in footnote 21.
[24] Testimony by Peggy F. Sheeler, R.N., executive director, Meals-on-Wheels of Central Maryland, at hearing cited in footnote 21.
[25] S. 1170 was signed into law on Nov. 7, 1977, Public Law 95-65.

In regulations issued November 22, 1977, the USDA allowed the choice for cash in lieu of commodities by each project. The cash value will be determined on the number of meals served during a previous quarter. This flexibility was unanimously welcomed by the nutrition project directors, as well as the State units on aging.

C. Senior Centers—Title V

Title V of the Older Americans Act defines a multipurpose senior center as "a community facility for the organization and provision of a broad spectrum of services (including provision of health, social, and educational services and provision of facilities for recreational activities) for older persons." Title V supports the acquisition, renovation, or alteration of a facility to be used as a multipurpose senior center. The title is intended also to support initial staffing and a mortgage insurance and interest grant program.

In 1977, a $20 million appropriation was allocated for title V, but only to support "Part A—Acquisition, Alteration, or Renovation of a Multipurpose Senior Center." In a response to a letter from Senators Harrison Williams, Thomas Eagleton, Frank Church, and Congressman John Brademas, the Department of Health, Education, and Welfare replied that in the allocation of the $20 million the "State agencies could be considered as eligible grantees, and as such would be able to contract with agencies and organizations to carry out the purposes of section 502." [26] This decision was in response to the congressional letter which questioned why title V had not been administered as a formula grant program during 1976 but instead as a direct grant allocation from the Commissioner to the local applicant. The Department reconsidered its position and allowed States to have the option of being a grantee for the fiscal year 1977 funding, but stood fast in its determination that the title V language did not allow for a formula grant program.[27]

The fiscal year 1977 appropriations was held up even longer by the delay in the final issuance of regulations governing title V. The delay was due to the Department's deliberation over whether "expansion" could be included under title V's allowance for alteration and renovation. After communication from the Senate Human Resources Committee and the Senate Special Committee on Aging,[28] which said that Congress had never meant to prohibit expansion, the Department promulgated regulations allowing expansions up to double the square footage of a facility to be included in the definition of renovation. The final regulations were finally published on July 5, 1977, clearing the way for the allocation of the $20 million to the States.

The funds were allocated to the States on the basis of their 60 and over population. In response to the Department's decision allowing States to be grantees, 47 States choose to do so. Idaho, Hawaii, Montana, and the Virgin Islands opted to continue direct funding from the Commissioner to the local applicants. The $20 million was distributed late in the fiscal year according to the following:

[26] Jan. 19, 1977, letter from Under-Secretary of Health, Education, and Welfare Marjorie Lynch to Senators Williams, Eagleton, Church and Congressman Brademas.

[27] "Formula grant" is when funds are distributed to the States based on their 60 and over population as defined by the Older Americans Act.

[28] Letter to Secretary of Health, Education and Welfare, Joseph Califano dated June 7, 1977, from Senators Williams, Javits, Eagleton, Chafee, Church, and Domenici.

Office of Human Development, Administration on Aging, proposed fund reservation level for fiscal year 1977, by States, under title V of the Older Americans Act of 1965, as amended

	Title V
Total 56 "States"	$20, 000, 000
Alabama	321, 111
Alaska	100, 000
Arizona	190, 884
Arkansas	224, 501
California	1, 759, 527
Colorado	181, 344
Connecticut	277, 557
Delaware	100, 000
District of Columbia	100, 000
Florida	1, 069, 758
Georgia	371, 192
Hawaii	100, 000
Idaho	100, 000
Illinois	986, 469
Indiana	448, 368
Iowa	296, 383
Kansas	231, 578
Kentucky	309, 414
Louisiana	295, 424
Maine	103, 807
Maryland	300, 396
Massachusetts	562, 653
Michigan	703, 821
Minnesota	360, 075
Mississippi	210, 109
Missouri	490, 645
Montana	100, 000
Nebraska	$157, 091
Nevada	100, 000
New Hampshire	100, 000
New Jersey	666, 976
New Mexico	100, 000
New York	1, 737, 513
North Carolina	429, 968
North Dakota	100, 000
Ohio	908, 280
Oklahoma	275, 478
Oregon	220, 020
Pennsylvania	1, 183, 261
Rhode Island	100, 000
South Carolina	202, 203
South Dakota	100, 000
Tennessee	374, 355
Texas	984, 397
Utah	100, 000
Vermont	100, 000
Virginia	372, 295
Washington	307, 212
West Virginia	181, 006
Wisconsin	428, 193
Wyoming	100, 000
American Samoa	50, 000
Guam	50, 000
Puerto Rico	176, 736
Trust territory	50, 000
Virgin Islands	50, 000

The $20 million was used to support approximately 1,500 facilities as multipurpose senior centers. Churches, schools, theaters, community centers, office buildings, mercantile stores, warehouses, hotel and motel buildings, and mobile homes were modified with the help of title V funds. These centers provided for services ranging from recreational to health care and coordinated with other aging service programs in the community. Title V was beginning to make its impact on the comprehensive services programs for the elderly in its second year of operation.

1. AOA MAJOR INITIATIVE

On November 8, 1977, Commissioner of the Administration on Aging, Arthur S. Flemming, issued a message to the heads of State and area agencies on aging dealing with a new major AoA initiative on senior centers. Dr. Flemming stated:

> We share a common responsibility to move rapidly in order to make sure that today's older persons benefit from these authorizations and appropriations. We can discharge this responsibility by the manner in which we pass on applications that are made by senior centers for the funding under title V; by the way in which we utilize title III and title VII funds in order to strengthen senior centers; and by the way in which we make sure that the resources of senior centers become an integral part of a coordinated and comprehensive community plan for the delivery of services to older persons.

The initiative called for two multipurpose senior centers in each State capable of providing a comprehensive and coordinated program for services within the community and aging network by March 31, 1979. The programs of these centers "should be designed to place major focus on the needs of the most vulnerable older persons in the community. The configuration of services provided should be structured to assist older persons to maintain independence in a home environment and continued participation in the community. Particular emphasis should be placed on the provision of day care and protective services for the physically and mentally impaired."

The initiative statement added that an "interagency agreement mechanism will be used to encourage the provision of additional support for services by sources outside AoA and for the colocation of staff on a part or full-time basis to provide services and outreach in senior center facilities."

In addition, "State and area agencies on aging, within the framework of their operating plans, will be urged to consider utilizing some of the additional resources being made available to them through titles III, V, and VII for the purpose of assisting in the development of as many of the multipurpose senior centers described above in each State as they can by the target date of March 31, 1979."

The initiative—which was endorsed by the Assistant Secretary of the Office of Human Development Services and the Secretary of Health, Education, and Welfare—gave rise to questions about the degree to which the initiative's guidelines were mandatory. In a meeting with the Commissioner on Aging on December 14, 1977, representatives of national organizations on aging and congressional staff heard the Commissioner stress that the initiative was "loose and flexible" and it would be the decision of the area agency to determine whether such priorities were applicable to its community. States and area agencies would not be required to change their 1978 plans which were in final drafting stages, but could make amendments on their own if circumstances warranted such changes.

2. SENATE HEARINGS

In cooperation with the Senate Subcommittee on Aging of the Human Resources Committee,[29] the Senate Special Committee on Aging held a hearing in October 1977 to explore issues related to title V.

In opening remarks, Senator Lawton Chiles said:

> The advent of title V funding is significant, but it is just one of the influences now at work in determining the place that senior centers will have in the so-called aging network of services and programs throughout the Nation. Centers by themselves, over the years, have developed their own priorities and their own place in the community. They stand ready, I believe, to take on additional responsibilities and significance.[30]

[29] The Senate Subcommittee on Aging of the Human Resources Committee has legislative responsibility for the Older Americans Act and agreed to work with the Senate Special Committee on Aging to hold hearings focusing on the extension of title V.

[30] Opening statement by Senator Lawton Chiles, presiding at Senate Special Committee on Aging hearing, "Senior Centers and the Older Americans Act," Oct. 20, 1977.

Witnesses concurred. E. Bentley Lipscomb, dirctor of the Florida State Office on Aging and Adult Services, testified on behalf of the National Association of State Units on Aging and said:

> Senior centers have proven in communities throughout the Nation that they can be the central point for services to the elderly, thus enhancing service coordination. They have proven that they can pull together and provide the entire array of health and social service required to sustain independent living. They have proven that they can greatly enhance the accessibility of the elderly to the services. And by their very diversity, they have proven that they can develop facilities and programs geared to the needs of the community in which they are based.[31]

The Administration on Aging testified:

> We expect that fiscal years 1978 and 1979 will mark significant forward steps in the development of multipurpose senior centers. We see these centers as a part of a continuum of services which must evolve rapidly to help impaired older persons maintain independent living. We see them also as focal points for helping older persons remain active participants in their communities.[32]

The National Association of Area Agencies on Aging said:

> Many area agency on aging directors recognize the value of having comprehensive senior centers within their planning and service areas. Just as the area agencies on aging are a critical link between the State agencies on aging and the elderly for the purposes of implementing the Older Americans Act programs, so can the senior centers play an effective role as a means by which the area agencies on aging can succeed in the development of a comprehensive services delivery system at the community level. It is incumbent upon all of us who are concerned about meeting the needs of the elderly to look at the successful examples of where senior centers are effectively utilized as a component of the comprehensive services delivery system and then build on those examples.[33]

Representatives of the National Institute of Senior Centers (NISC) said:

> Multiple services under an umbrella agency, such as a multipurpose senior center, provides a focal point for service delivery in the local communities. The community draws upon the senior center to identify and address senior adult needs, problems and issues. Cooperative agency planning, organizing, coordinating and advocacy for senior adult services enhances the role of senior centers as viable components of this service provider system.

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[31] Testimony by National Association of State Units on Aging at hearing cited in footnote 30.
[32] Testimony by the Administration on Aging at hearing cited in footnote 30.
[33] Testimony by the National Association of Area Agencies on Aging at hearing cited in footnote 30.

Referring to a center in Rhode Island, the NISC witness said:

> Our center provides information and referral; health screening; education lectures, benefits, SSI, etc.; meals, 5 days a week; direct service; group services; humanities program; a special emphasis program which is focused on the frail elderly and independent living; home health maintenance/friendly visiting; volunteers to nursing homes; transportation; leadership training; student placement; physical and occupational therapy; limited chore services; trips; serving on boards and planning committees; spiritual life services; and advocacy.[34]

All of the witnesses endorsed the continuation of title V as an important link in the comprehensive services program under the Older Americans Act. All agreed that making it a formula grant program would enhance this possibility and make it an effective tool in cooperation with titles III and VII and other service programs.

D. Training and Research—Title IV

Service programs under the Older Americans Act are supported by training and research efforts under title IV of the act, training and research. These efforts are often coordinated with the services delivery systems and operations of State and area agencies, title VII projects and senior centers. With the exception of some training moneys which are allocated to the States, most of the training and research awards are made as discretionary grants by the Commissioner. In fiscal year 1977, the appropriation was $26.5 million for title IV—$14.2 million for training, $8.5 million for research, and $3.8 million for multidisciplinary centers of gerontology.

1. IN-SERVICE TRAINING

During 1977, title IV–A supported 384 training sessions for aging service personnel. These sessions were supported by $751,426 of title IV funds and $56,591 of title III funds. According to AoA records, 33,088 persons were trained during fiscal year 1977, including: 1,396 State agency staff, 3,394 area agency staff, 3,665 nutrition project staff, 2,059 advisory committees and council members, 2,796 volunteers, and 19,778 "public and private persons" (service providers not employed directly by Older Americans Act programs).

The title IV–A training funds allocated to the States are based on the States' 60-and-over population. These funds are governed by specific guidelines from the AoA which require that a minimum 50 percent be used for the development and delivery of training programs for the area agencies and 67 percent shall be awarded to postsecondary education institutions to perform the training sessions. The States were also encouraged to use a portion of their training funds to train persons involved with the statewide legal services and nursing home ombudsman projects.[35]

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[34] Testimony by National Institute of Senior Centers at hearing cited in footnote 30.
[35] Program Instruction of Administration on Aging (AoA–PI–77–13), Mar. 5, 1977.

2. CAREER TRAINING AND PLANNING GRANTS

Career training grants are awarded to institutions of higher education to "prepare students to acquire the necessary gerontology-related knowledge that will enable them to serve the Nation's elderly in their chosen career or profession." [36] During 1977, the Administration on Aging supported 59 institutions of higher education with title IV career training grants.[37]

Planning grants were awarded to 20 institutions of higher education [38] "to assist in supporting a limited number of planning efforts by institutions of higher education to develop multidisciplinary gerontology capability and interest within the educational institution." [39]

In addition, the Administration on Aging supported several developmental and quality improvement grants under title IV. These grants were awarded to "support such activities as the design, development, and evaluation of exemplary training programs, the introduction of high quality and more effective curricula and curricula materials, the provisions of increased opportunities for practical experience in the field, and the promotion of gerontology into career fields that in practice have not been responsive to the needs of older persons." [40] Fourteen developmental and quality improvement grants were awarded in 1977.[41]

3. RESEARCH GRANTS

In an effort to coordinate the research efforts of the Administration on Aging with the aging network operations, the Commissioner of the AoA made a commitment that "funding decisions by the Commissioner will be based on comments and recommendations from three sources: the technical review panel of peers, State agencies on aging; and the

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[36] "Training and Manpower Development Activities Supported by The Administration on Aging Under Title IV-A of the Older Americans Act of 1965, as Amended," (Descriptions of Fiscal Year 1977 Funded Projects), DHEW Publication No. (OHDS) 78-20118.

[37] University of California (2); San Diego State University; University of California at San Francisco; Los Angeles Harbor Community College; Adams State College, Colorado; University of Denver; The George Washington University, Washington, D.C.; The George Washington University National Law Center; The University of the District of Columbia; University of Florida; University of South Florida; Albany State College, Georgia; Georgia State University; North Georgia College; The University of Hawaii at Manoa; The University of Chicago; Wichita State University; Southern University, Louisiana; University of Maine at Portland-Gorham; University of Maryland; Antioch College, Maryland; Boston University; The University of Michigan; Wayne State University, Michigan; Western Michigan University; Madonna College, Michigan; University of Minnesota; University of Missouri at Columbia; St. Louis University; University of Nebraska at Omaha; Rutgers, The State University; State University of New York at Buffalo; City University of New York; Hunter College, New York; Syracuse University; Wayne Community College, North Carolina; Livingstone College, North Carolina; University of Akron, Ohio; Case Western Reserve University, Ohio; Miami University, Ohio; University of Oregon; Portland State University, Oregon; Pennsylvania State University; University of Rhode Island; Middle Tennessee State University; Fisk University, Tennessee; Bishop College, Texas; North Texas State University; Our Lady of the Lake University of San Antonio; Prairie View A&M University, Texas; University of Utah; Hampton Institute, Virginia; Norfolk State College, Virginia; West Virginia University; University of Wisconsin at Madison; and University of Wyoming.

[38] University of Alabama; Charles R. Drew Postgraduate Medical School, California; Los Angeles Valley College; Kansas State University (graduate school); Northeast Louisiana University; Eastern Michigan University; University of Nevada at Las Vegas; Seaton Hall University, New Jersey; Fordham University New York; Yeshiva University Gerontological Institute, New York; Marist College, New York; Capital, University, Ohio; Kent State University, Ohio; Northeastern Ohio Universities College of Medicine; Temple University, Pennsylvania; King's College, Pennsylvania; Huron College, South Dakota; University of Texas at Austin; Bellevue Community College, Washington; and West Virginia University.

[39] Reference cited in footnote 36.

[40] Reference cited in footnote 36.

[41] Senior Adults Legal Assistance, California; California Department on Aging; Antioch School of Law, Washington, D.C.; American Alliance for Health, Physical Education and Recreation; American Personnel and Guidance Association; Gerontological Society; National Center for the Black Aged, Inc.; National Council on the Aging, Inc.; National Paralegal Institute; University of Maryland; Jewish Institute for Geriatric Care, New York; Council on Social Work Education, New York; Syracuse University; and Duke University Medical Center, North Carolina.

staff of the Administration on Aging." [42] Title IV–B research grants may, according to the act, be made to any public or private nonprofit agency, organization, or institution and contracts may be awarded to any agency, organization, institution or individual. During 1977, 69 grants and contracts were made to approximately 50 researchers, as follows:

Grantee	*Title*
University of Southern California	A Comparative Applied Study of Health, Retirement and Housing Issues Affecting Mexican-American, Black and White Elderly.
Asociacion Nacional Pro Personas Mayores.	A National Study to Assess the Service Needs of the Hispanic Elderly.
The Urban Institute, Washington, D.C.	Forecasting the Changes in the Characteristics of Older Persons Between Now and 1990.
Georgetown University, Washington, D.C.	Cohort Composition and Changes in the Elderly Population 1975–90.
University of Miami, Florida	The Economic, Social and Psychological Impacts on the Elderly Resulting From Criminal Victimization.
Philadelphia Geriatric Center	The Elderly and Their Housing 1973–77.
San Diego State University	The Servidor System.
American Institutes for Research, Washington, D.C.	"With a Little Help From My Friends."
National Center for Black Aged	Informal Social Networks in Support of Elderly Blacks in the Black Belt of the United States.
University of Illinois at Chicago Circle.	Aging, Social Isolation, and Kinship Ties Among Japanese-Americans.
Massachusetts Institute of Technology.	New Community: A Documented History of a Congregate Residence.
Hebrew Rehabilitation Center for Aged, Massachusetts.	A Study of the Informal Support Network of the Needy Elderly.
Hunter College, New York City University of New York.	The Impact of the Entry of the Formal Organizations on Existing Networks of Older Americans.
Regents of the University of Michigan.	American Values and the Elderly.
Trustees of the University of Pennsylvania.	Aging With Television.
Philadelphia Geriatric Center	The Dependent Elderly and Women's Changing Role.
University of Southern California	Alternative Designs for Comprehensive Service Delivery to the Elderly Through Case Service Coordination/ Advocacy.
Foundation of California State University, Sacramento.	Techniques of Social Service Provision to the Minority Aged.
County of Los Angeles Area Agency on Aging.	Community Analysis Techniques.
University of Miami, Florida	Reaching Out to the Hispanic Elderly.
Wayne State University, Michigan	An Investigation of the Feasibility of a Computerized Model of the Provision of Services to the Elderly.
Regents of the University of Michigan.	Home Health Care Among Black Elderly.

[42] Guidelines for Preparation of Grant Applications, Research and Development Projects in Aging Title IV–B of the Older Americans Act for Fiscal Year 1977, Department of Health, Education, and Welfare, July 1, 1977.

Grantee	Title
State of Washington, Department of Social and Health Services.	Models of Case Coordination for Provision of Services to the Elderly.
The Urban Institute, Washington, D.C.	Cost Analysis of Services to the Aged.
The Institute of Public Administration, Washington, D.C.	Information Dissemination Models on Transportation Services for Older Americans.
Institute for Economic and Social Measurements, Inc., Maryland.	Analysis of the Continuation of Services Funded Under Title III.
The Urban Institute	The Development of an AoA Strategy for Policy Research in Aging: Health and the Elderly.
Regents of the University of Michigan	Data Archives, Training and Consultation Services in the Field of Aging.
University of Southern California	Aged and Pre-Aged Women: Analysis of Needs (Successful Work Options of Aging Women).
American Institutes for Research	Identifying Opportunities for Improving the Quality of Life of Older Age Groups.
University of Florida	Organization of Cognitive Abilities.
University of Georgia	Socialization to Old Age in an Urban Setting.
University of Chicago	Crisis and Adaptation in Middle and Late Years.
University of Chicago	Decision-Making and the Elderly.
University of Maryland	Aging Competency.
University of Missouri-Columbia	Local Socio-Environmental Contexts and Personal Moorings Related to Decision-Making and the Elderly.
Duke University	Changing Household Patterns Among the Elderly.
Duke University	Group Behavior and Socialization Experiences.
Philadelphia Geriatric Center	The Elderly and Their Housing.
University of Pittsburgh	Consumerism and the Aging: The Elderly as Victims of Fraud.
Battelle Human Affairs Research Center, Washington.	Consumerism and the Aging: The Elderly as Victims of Fraud.
Catholic University of America, Washington, D.C.	Informal Social Networks and Assistance Among the Elderly.
The Conservation Foundation Washington, D.C.	Impact of Neighborhood Conservation on Older Americans.
Bowman Gray School of Medicine, Wake Forest University, North Carolina.	Incentives and Family Environments for the Elderly.
The Mitre Corporation, Virginia	Technology in the Services of the Aged Through the Retirement Cooperative Concept.
Special Services for Groups, Inc., California.	Service Delivery Models for Pacific Asian Elderly.
The Urban Institute	Client Oriented Community Assessment of Long-Term Care Facilities.
University of Kansas	Attitudes Towards Older Persons on the Part of Service Delivery Professionals.
Division of Youth and Family Services, Department of Institutions and Agencies, State of New Jersey.	The Utilization of the Elderly in Child Welfare Services.
Portland State University, Oregon	Attitudes Towards Older Persons on the Part of Services Delivery Professionals.
Portland State University	Analysis of Coordination and Organization Change.
Portland State University	Testing a Community Intervention Model.
Human Resources Research Organization, Virginia.	Analysis of Employment Services for Older Job Seekers.
Curative Workshop of Milwaukee, Wisconsin.	Avocational Counseling for the Elderly.

Grantee	*Title*
Regents of the University of California (San Francisco)	Funding Practices, Policies, and Performance of State and Area Agencies on Aging.
Scientific Analysis Corporation, California.	An Analysis of the Implications of Title XX Service Plans for the Nationwide Development of Local Comprehensive Services Delivery Systems for the Aged.
University of Southern California	Study of Funding Regulations, Program Agreements, and Monitoring Procedures Affecting Implementation of Title III of the Older Americans Act.
Northern Illinois University	Development and Adoption of Policies for the Elderly: The State Legislative Process.
Center for Public Management, Maryland.	Strengthening Decisionmaking for Alternative Approaches to Conducting In-service Training.
Community Research Applications, Inc., New York.	Technical Assistance to the National Network on Aging: Handbooks on Priority Services for Older Persons.
Pennsylvania State University	Simulating Demand and Costs for Statewide Services to the Aging.
American Institutes for Research, Washington, D.C.	Impact of Unemployment Climate on Older Workers in Two Labor Markets With Contrasting Unemployment Rates.
University of Virginia	Implications of Prospective Population Change for Older American Workers.
Regents of the University of Wisconsin.	Development of an AoA Strategy for Policy Research in Aging: Employment, Retirement, and the Elderly.
Brandeis University, Massachusetts	Approaches to Determining the Cost of a Home Care Alternative to Nursing Home Care: The Diversion Strategy.
Governor's Citizens Council on Aging, Minnesota.	Comparison of In-Home and Nursing Home Care for Older Persons in Minnesota.
Research Foundation for Mental Hygiene, New York.	A Cross National Comparison of the Institutional Elderly; Including Costs, Quality, and Outcome of Their Long Term Care.
Public Interest Law Center of Philadelphia.	Planned Crises/Disasters: Nursing Home Closings.
University of Utah	The Impact of Inter-Institutional Relocation on Geriatric Patients.
Documentation Associates, California.	Inventory of Federally Sponsored Research on Aging: 1965–75.
University of Southern California	Integration of Information on Aging: Handbook Project.

4. MULTIDISCIPLINARY CENTERS OF GERONTOLOGY

In its second year of funding, title IV–C of the Older Americans Act had an appropriation of $3.8 million. These funds were used to support what the act refers to as "multidisciplinary centers of gerontology," which may be within public or private nonprofit agencies, organizations, and institutions. The multidisciplinary centers must provide activities related to promoting gerontology within their given programs, including: recruiting and training; basic and applied research; consultation; serving as a repository of information; creating opportunities for innovative, multidisciplinary efforts in teaching, research, and demonstration projects; and stimulating the incorporation of information on aging into the teaching of the biological, behavioral, and social sciences.

During 1977, 43 awards were made under title IV–C—20 of these were continuation awards to grantees who had received funds during 1976, and 23 of the awards were classified as "new awards" for developmental or operational costs of a multidisciplinary center of gerontology.[43]

II. MAJOR ISSUES RELATED TO RENEWAL

A lengthening list of issues related to renewal of the Older Americans Act has been in the making ever since transition teams prepared option papers late in 1976 and early 1977 for the incoming Carter Administration.

The following summary is by no means complete, but it offers a guide to several major considerations requiring close congressional attention in the renewal process.

A. An Independent or Strengthened AoA

The Senate Committee on Aging has had a long-standing interest in AoA's placement in the Federal structure. In 1971, Senator Church called together a 20-member task force to consider alternatives for strengthening AoA or providing a successor. The task force concluded:

> . . . the AoA falls far short of being the Federal "focal point on aging" sought by Congress. Instead, its concerns are splintered and scattered; there are limited, if any, policies and few clear-cut goals. Recent reorganizations have not strengthened Federal programs and commitment in aging in any way. Rather, they have fragmented an already flawed and feeble agency still further. This situation has created chaos as well as a lack of direction in Federal and State programs.[44]

The task force report provided a rationale for moving AoA out of the welfare-oriented Social and Rehabilitation Service under the Older Americans Comprehensive Services Amendments of 1973. But 5 years later, questions still remain about the appropriate role and placement of AoA. Several alternatives have been advanced in one form or another by leaders in the field of aging. Among the major arguments for and against proposed organizational changes:

PROPOSALS—ARGUMENTS FOR AND AGAINST

Proposal 1: Remove AoA from the Office of Human Development Services and give it a direct line responsibility to the Secretary of HEW

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[43] The continuation awards were classified as developmental and operational, and included: Developmental grants: Florida State University; North County Community College, New York; Davis Institute for the Care and Study of the Aging, Colorado; University of Pennsylvania; University of Illinois at Chicago Circle; University of Iowa; University of Hawaii; University of Connecticut; University of Alabama; City University of New York; University of Alabama; University of Miami, Fla.; University of Kentucky. Operational grants: Syracuse University; University of Southern California; Pennsylvania State University; Duke University; North Texas State University; Miami University, Ohio; Boston University.

The "new awards" were made to: Developmental grants: University of Louisville; Temple University, Pennsylvania; San Diego State University; University of Pittsburgh; University of Oregon; University of Minnesota; State University of New York at Albany; University of Akron, Ohio; University of Nebraska; Hampton Institute, Virginia; Wichita State University; Virginia Commonwealth University; University of Puerto Rico; University of Kansas; West Virginia University. Operational grants: University of Missouri; Hunter College, New York; University of Wisconsin; Philadelphia Geriatric Center; University of Michigan; University of Washington; Portland State University, Oregon; Wayne State University, Michigan.

[44] "The Administration on Aging—Or A Successor?," a report to the Senate Special Committee on Aging, October 1971. p. 2.

or simply allow AoA to report directly to the Secretary (instead of the "Office of the Secretary.")

Pro: (a) This would give AoA greater status and impact. (b) It would provide a direct line of communication with the Secretary of HEW.

Con: (a) In the final analysis other factors (such as funding) determine the success or failure of Federal programs for older Americans—instead of AoA's place in the Government's structure.

Proposal 2: AoA should be established as an independent agency within HEW and headed by an Assistant Secretary on Aging (recommended by the National Council on the Aging).

Pro: (a) AoA is not able to influence programs administered by other HEW units, since it is one small unit within OHDS. (b) This action would elevate AoA, giving it a stronger hand to coordinate HEW activities affecting elderly persons. (c) Placing authority in an Assistant Secretary would give more prominence to the central spokesperson in government for the elderly.

Con: (a) An Assistant Secretary would still be accountable to the Secretary of HEW. If the Secretary gives issues affecting the elderly a low priority, the Assistant Secretary would be little more than a figurehead.

Proposal 3: Establish an independent AoA outside the Department of HEW.

Pro: (a) This agency would provide effective coordination and leadership for aging programs because it would be a high level and independent unit. (b) An independent agency would probably be more successful if an administration was unsympathetic to senior citizen programs.

Con: (a) This proposal would have little likelihood of adoption, in view of the administration's reorganization strategy. (b) An independent AoA would be isolated from other service delivery mechanisms and programs in HEW and/or other Federal agencies or departments.

B. Possible Merging of Titles III, V, and VII

A key issue for the "aging network" during 1977 and early 1978 was the possibility of consolidating titles III, V, and VII into one title under a formula grant. This merger would direct funds for area planning and social services, senior centers and nutrition programs (whether as separate authorizations or one authorization), through State units on aging to area agencies on aging (where they exist,) or planning and service areas. This method is now practiced in some areas but is optional with local agencies. The merger of titles III, V, and VII in the amended act would make cooperation mandatory at each local level.

The merger of title V with title III apparently does not face as much opposition as the merger of title VII. On February 28, 1978, Senators Pete V. Domenici, Edward W. Brooke, Charles H. Percy, and others introduced legislation (S. 2609) which would consolidate titles III and V but would leave title VII separate. Other proposals by Senator Church (S. 2969), Senator Eagleton (S. 2850), and Congressman Brademas (H.R. 12255) would merge all three titles under one comprehensive title III.

A merger of titles III and VII would probably mean that all title VII projects would be under the auspices of the local area agency on

aging. The National Association of Title VII Project Directors and the National Association of Area Agencies on Aging had sharply contrasting views on this issue.

The National Association of Title VII Project Directors was "diametrically opposed to forced merger by the Federal or State agency. . . The National Association of Title VII Project Directors supports current legislation that states and mandates that title VII projects have the option to function independently."[45]

The National Association of Area Agencies on Aging expressed the opposite view:

> All titles of the Older Americans Act should be administered through the Administration on Aging, State units on aging, and area agencies on aging, on a formula grant basis in order to enhance coordinated administration of all Older Americans Act programs and to support the concept that the State and area agencies are a focal point for coordinating and pooling both public and private resources on behalf of the Nation's elderly.[46]

The Congressional Research Service of the Library of Congress has prepared a summary of the major arguments for and against merger.[47] Among the arguments for the merger:

—Eliminating duplicative and overlapping administrative functions (i.e., outreach, advocacy, pooling and coordinating, training, and planning).

—Providing one screening agency (the area agency) for determining the needs of the elderly and their eligibility for services.

—Giving more visibility and strength to the area agencies in the community, presumably increasing their ability to provide more and better services for the elderly; and

—Allowing planning from a joint perspective and giving more flexibility with regard to budgetary decisions.

Arguments for retaining the separate titles include:

—The purposes and functions of these programs (titles III and VII) differ from one another in that title III provides for planning and development while title VII provides for the direct provision of social services. Title VII is primarily an ongoing social service while title III provides seed money for services. Title III funds may be used to supplement title VII projects, but title VII funds never supplement the title III programs.

—Title III area agencies have less experience in planning and delivering services than title VII grantees, which often have had longstanding experience in social service delivery,

—Title III is already administered in close coordination with title VII in a way which maximizes the implementation of title VII; and

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[45] Testimony by Jack Anderson, chairperson of National Association of Title VII Project Directors, before the Senate Subcommittee on Aging, Feb. 7, 1978.

[46] Testimony by Leon Harper, president of the National Association of Area Agencies on Aging, at hearing cited in footnote 45.

[47] "Arguments Pertaining to the Merger of Title III and Title VII Programs Under the Older Americans Act," by Evelyn Tager of Education and Public Welfare Division, Congressional Research Service, Library of Congress, June 1977.

—The area agencies have a unique role which allows for flexibility and the development of needed social services at the local level. Their expertise can be shared with title VII staff and other social service providers for the elderly.

C. Role of the Area Agency on Aging

Under Title III of the Older Americans Act, a State plan is required to assure "that no social service will be directly provided by the State agency or an area agency on aging except where, in the judgment of the State agency, provision of such service by the State agency or an area agency on aging is necessary to assure an adequate supply of such service."[48]

This provision has led to much discussion of a core question: Should the State and area agencies be more involved in the direct provision of services or should it concentrate on its administrative duties of pooling, coordinating, and tapping other services?

As recorded in section I of this chapter, the State and area agencies are reportedly becoming more adept in their pooling and tapping responsibilities and have been able to secure numerous dollars from other programs in their communities. Yet, in many areas, especially in less densely populated sections of the country, there are few services to pool and tap. Therefore, area agencies utilize a large proportion of their title III allocation for direct services.

Recommendations from the field differed widely.

The director of the New York Office on Aging told the committee:

> The primary issue facing Congress as it considers reauthorization of title III is how to strengthen the role and authority of the area agencies by building upon the positive aspects of the current structure. To me this means, simply stated, more emphasis upon coordination and pooling, through increased control of available resources, *combined with greater capacity to provide direct services, including case management.*[49] [Emphasis added.]

Mrs. Glasse added:

> Many people have voiced a legitimate fear that if area agencies become too deeply involved in providing direct services their responsibilities for coordination, pooling, and advocacy may suffer. Yet, it is commonly accepted that area agencies have a critical role to play in the provision of direct services in rural areas where other community services are scarce or nonexistent. I believe it is also time to recognize, despite the fact that most urban and suburban areas are comparatively richer in resources than rural areas, that the need for direct services provision in nonrural areas is also critical considering the fragmentation and gaps which exist.
>
> The dual role of direct service provider and advocate/coordinator can be accomplished if a clear distinction is made

[48] Public Law 89-73, as amended; section 305(a)(8).
[49] Statement by Mrs. Lou Glasse, director, New York State Office for the Aging, at workshop cited in footnote 5.

within the area agency's organizational structure. When the State Office in New York recently established a program and policy analysis unit to improve its advocacy and coordination activities, the office clearly separated this unit from operational units charged with administration of titles III, V, VII, and other State level programs. With a strict separation of functions and staff responsibilities, we are able to discharge operational and advocacy responsibilities without conflict. Many of our area agencies have successfully adopted a similar model involving direct services delivery and subcontract management on the one hand, and advocacy, planning, and coordination on the other.

Several advantages to AAA's of direct services provision include a closer association with older people, increased status within the services network, as well as the provision of services which otherwise would not be accessible.

I am not recommending that all area agencies be required to provide direct services, but rather that broader authorization be granted for area agencies to do more when they perceive more is needed.

The National Council of Senior Citizens strongly disagrees with the direct service function for State and area agencies:

> Therefore, performing the role of service provider when other public or private channels exist merely reduces the State or area agency on aging to simply another competitor for limited service funds and destroys its credibility as a planning, coordinating, and advocacy body.[50]

The National Association of Area Agencies on Aging recommended that the provision of the law regarding direct service be retained but amended to include an additional factor which considers the quality of service provided when determinations are made whether a State or area agency can provide a direct service.

Also supporting the law as it now reads is the American Association of Retired Persons. In testimony before the Senate, AARP recognized the value of the section 305 provision, but stated that "area agencies should be free to do the job of planning, advocacy and information and referral which they are expected to perform. They should not be in competition with local public or private voluntary agencies." [51]

Recognizing the differences in geographical and demographical characteristics among and within the States, most aging groups and practitioners agree that the existing provision and forthcoming amendments should retain the flexibility for direct service provision where necessary. The differences in opinion arise when recommendations are made regarding where the emphasis should be placed, or if any emphasis should be included at all.

D. Priority Services

Another area of major concern regarding the role of the area agency during 1977 centered on the four priority services mandated by the

[50] Testimony by William R. Hutton, executive director, National Council of Senior Citizens, at hearing cited in footnote 2.

[51] Testimony by John B. Martin, legislative consultant, National Retired Teachers Association and American Association of Retired Persons, at hearing cited in footnote 2.

1975 amendments.[52] The requirement that a State must spend 20 percent of its title III area planning and social services on one or a combination of transportation, legal and counseling services, home services, and home repair and renovation was seriously opposed by the State and area agencies on aging who felt that such determinations should be left to the State and local levels.

The National Association of State Units on Aging and the National Association of Area Agencies on Aging told the Senate that the "setting of national priority services within the Older Americans Act is inconsistent with the mandate that service be provided in response to identified needs of the elderly at the State and local level." [53]

At the request of Congress, the General Accounting Office studied several State and area agencies on aging to determine the effect of the priority services mandate on their planning and service activity over the last year.[54] Concluding that the priority services had had "little effect" on the planning and spending by States and area agencies, the GAO stated:

> State officials believed that increased spending was not attributable to the 1975 amendments and State and local program officials resent the 1975 amendments because they have infringed on the local planning philosophy of the Older Americans Act.[55]

The GAO found that the States and area agencies had already been giving some attention to the so-called priority services for some time and were already spending a significant amount of funds in one or a combination of these areas. In addition, the GAO states that "all the States we visited could have reduced their expenditures for priority services in fiscal years 1976 and 1977 and still have complied with the spending requirements of the 1975 amendments."

However, the priority services had a negative effect, according to the GAO, by causing additional financial and administrative problems in program reporting requirements. State and area agencies reported that it was very difficult to break down expenditures under the act because many of title III funds are seed moneys or startup funds to tap other service dollars. Therefore, the requirement of the 1975 amendments resulted in substantial reporting and recordkeeping that was inconsistent with the effect of priority services.

Recognizing these findings, the GAO recommended to the Congress:

—To continue to emphasize the four priority services; and

—Explore the desirability of removing the minimum funding requirements for priority services as mandated in the 1975 amendments.

E. Minority Group Dissatisfaction

Treatment given to minority group members—either as persons in need of service or as potential employees in the aging "network"—was the target of renewed complaints at the February 3, 1978, Senate hearing on Older Americans Act extension. (See chapter X, section I,

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[52] See section I of this chapter for discussion of priority services.

[53] Testimony by Gerald A. Bloedow, president of the National Association of State Units on Aging, and Leon Harper, president, National Association of Area Agencies on Aging, at hearing cited in footnote 2.

[54] The Senate Subcommittee on Aging and Special Committee on Aging, and the House Committee on Education and Labor and Select Committee on Aging, requested the GAO to conduct this study.

[55] "The 1975 Amendments to the Older Americans Act—Little Effect on Spending for Priority Services," report by the Comptroller General of the United States, Mar. 6, 1978.

for additional discussion of minority concerns in the Older Americans Act and other programs.)

Dr. Aaron E. Henry, chairman of the National Caucus on the Black Aged, said that a new report of the U.S. Commission on Civil Rights on Age Discrimination (see chapter IX) did not go far enough. He proposed that the Congress order "the Commission on Civil Rights to undertake a comprehensive study of racial discrimination in services, in employment, and in contracts in all programs and activities receiving Federal assistance which affect older persons."

Such a study, he added, "will uncover many instances in which the black elderly and other minority elderly are not sufficiently provided for, and that there is a proportionately large void of minority service providers, and that minority personnel are underrepresented in administrative capacities in program agencies."

Referring specifically to the Older Americans Act, Dr. Henry said that despite "repeated reference in the act and its regulations to the notion that those elderly who are either minority groups members or who are at or near the poverty level, or both, should be given priority," many persons in greatest need are neglected.

He added: "The likelihood of being poor among elderly blacks is almost three times as great as for aged whites."

Dr. Aaron also said the Westat report (see section I of this chapter) stated that minorities were sparsely represented among area agency staffs, but in Dr. Aaron's view, "The Westat findings provide only a glimmer into the pervasive pattern of racial and minority exclusion."

The Hispanic perspective was presented by Carmela Lacayo, director of the Asociacion Nacional Pro Personas Mayores. She called for "strengthening the affirmative action criteria in the act and for tough new language mandating affirmative action enforcement," because "my community has essentially been ignored by the Federal aging network and has not been included in the activities and services provided under the act."

Examples from Ms. Lacayo included:

—"In a recent study of title VII projects . . . only 4 out of 12 project site locations in the bay area met the criteria of low income. . . . This situation is not unique . . . it occurs in every State served by region IX."

—Information and referral services are often useless: "Time and again our viejitos give up in frustration trying to communicate with their area agency or contractors from the area agency."

—An Asociacion survey in February 1977 found that State plans on aging in most States include provisions for the Hispanic elderly, but such provisions "are vague, and therefore not enforced."

Ms. Lacayo recommended that area agency directors have affirmative action responsibility and accountability, subject to monitoring by State and regional level directors. As to enforcement, she asked for representation at State level hearings on the areas plan, followed by State allocations, if necessary, to assure proportionate recognition of low-income or minority individuals.

George Effman, chairman of the National Indian Council on Aging, said that a major council goal is to allow "its elderly to live out their lives in a familiar, traditional surrounding."

He added:

> The Indian elderly are a small and neglected part of our society. Many of them speak English only as a second language or not at all and subsist on little or no income. Their housing facilities are substandard, and their general health is poor.

Mr. Effman placed special emphasis on the Indian self-determination. (See the next section of this report and chapter X, section I for additional details.)

F. Direct Funding of Indian Tribes

The Older Americans Act now provides direct funding of Indian tribes, provided the Commissioner on Aging determines that (1) Indian tribe members are not receiving benefits equivalent to other older persons in a particular State, and (2) they would be better served through direct funding. However, this authority has never been exercised.

Support for a direct funding provision without conditions gained support from key national older Americans organizations and Members of Congress in 1977 and early 1978. The National Indian Council on Aging, Inc., cited four legislative precedents for authorizing direct funding of Indian tribes:

(1) Title IV of the Public Works and Economic Development Act.
(2) The Comprehensive Employment and Training Act (CETA).
(3) The State and Local Fiscal Assistance Act (revenue sharing).
(4) The community development block grants program under the Housing and Community Development Act of 1974.

George Effman, chairman of the National Indian Council on Aging, Inc., gave this rationale for direct funding:

> The direct funding approach, we believe, will open up the doors to many of the programs which are now often inaccessible to Indian tribes. According to statistics available to the National Indian Council on Aging, Indians are not receiving services equivalent to those provided members of other groups and there is a compelling need, based on historic and legal trust relationships between the Federal Government and the Indian tribes to administer these programs at the national level via direct funding mechanism.[56]

Senator Church emphasized in his testimony before the Human Resources Subcommittee on Aging that separate authorization could fund a larger-scale services effort. He added:

> The needs of aged Indians are intensified because of geographic isolation from supportive services, lower life expectancy, substandard housing, and widespread poverty.[57]

The National Council on the Aging also supported direct funding of Indian tribes and Alaska Native entities at the option of the tribal governments. Jack Ossofsky, NCOA executive director, said:

> The sovereignty and autonomy of tribes, as recognized by the Federal Government in other federally supported programs, makes it appropriate for the Commissioner on Aging

[56] Testimony at hearing before the Subcommittee on Aging of th,e Senate Committee on Human Resources on extension of the Older Americans Act, Feb. 3, 1978,
[57] Testimony at hearing cited in footnote 56.

to pass OAA funds directly to the tribes at their option. Tribes with good working relationships with State governments should be free to continue such productive partnerships.

NCOA believes that the tribal governing bodies are in the best position to meet the special cultural, emotional, and nutritional needs of their older members. Also, since tribes receive other Federal funds such as general revenue sharing directly, they are in a better position to combine financial resources in aging programs. While some tribes have received OAA funds directly as area agencies on aging, they are too few, and this designation does not acknowledge the unique historic and legal trust relationship between the Federal Government and Indian tribes.[58]

Senator Pete Domenici introduced the Older Americans Amendments of 1978 (S. 2609) on February 28, 1978, and Senator Frank Church introduced the Older American Act Amendments of 1978 (S. 2969) on April 20, 1978. S. 2609 and S. 2969 would provide a direct funding authorization to tribal organizations as part of a new title under the Older Americans Act. If less than $5 million is appropriated, the direct funding mechanism would not be triggered. Indian tribes would then receive services as they do now. S. 2609 would also convert surplus Indian educational facilities into senior centers, nutrition sites, and extended care facilities.

G. Proposed Reorganization of the Administration on Aging and Office for Human Development Services

Late in 1977, the Department of Health, Education, and Welfare announced a reorganization of the then Office of Human Development (now Office of Human Development Services) under which the Administration on Aging functions. The reorganization was submitted in two parts—one on functions and the second on structure.

The functions part was for the purpose of "the alignment of authority with responsibility and the delineation of staff roles that are truly supportive of program operations." [59] Broad management functions were broken down in specific categories: policy development functions, external relations functions, and support functions.

The policy development functions addressed several issues, such as the OHDS role with program commissioners. For example, AoA would retain all of its program development and administration as well as policy development. But it would receive general guidance from OHDS. In addition, it would submit each program and development to OHDS for approval. However, the Assistant Secretary of OHDS would retain a "cross-cutting and program-specific guidance" over certain operations, providing detailed program guidance and substantial operating responsibilities within these functions. Those functions would include planning, budget formulation, legislative development, regulations development, research and evaluation, and program data systems. One specific concern to national aging organizations was the proposal to allow OHDS to claim 15 percent of each of its subunits (including AoA) research budgets for overall research

[58] Testimony at hearing cited in footnote 56.
[59] Statement by Arabella Martinez (Assistant Secretary for Human Development Services) on OHDS Reorganization, Department of Health, Education and Welfare, Oct. 11, 1977.

of OHDS programs. This was perceived as a siphoning off of an already small research budget under the Older Americans Act.

The reorganization proposes several changes in the areas of public affairs and regional operations. In both areas, a "shared responsibility" was recommended in order that a single focal point within OHDS be maintained within the central office and regional offices. Program units would retain their own regional support capability.

S. 2609, which was introduced on February 28, 1978, by committee members Domenici, Brooke, and Percy, would remove AoA from OHDS and place it instead in the Office of the Secretary of HEW. In his introductory remarks, Senator Domenici stressed that:

> Over the years it has been the goal of Congress to strengthen the Administration on Aging, increase its visibility, and protect its institutional integrity in the face of constant departmental reorganizations. This legislation will move the Administration on Aging out of the Office of Human Development Services (OHDS) and make the Commissioner on Aging directly responsible to the Secretary of Health, Education, and Welfare. This action is designed to strengthen the Administration on Aging and undo some of the damage that has been done to it by the recent restructuring of OHDS.[59a]

In exploring another important element in the AoA/OHDS relationship, Senator Domenici expressed his strong opposition to recent efforts to transfer control over part of AoA's research budget to OHDS.

> I was also disturbed by the recent decision of the Assistant Secretary of Human Development Services to withhold 15 percent of AoA's research funds for use at the departmental level. I believe that we must preserve the commissioner's control over all AoA research funds and prohibit such skimming off by higher officials in the department.[59b]

Several recommendations were made to reorganize and coordinate responsibilities, including formula grant management, project grant administration, budget execution, personnel and administrative services. Again, this was a major issue to the national organizations already concerned about the small staff at the Administration on Aging and its regional offices. This concern has been reinforced by reorganization efforts to centralize some staff from subunits within OHDS.[60]

The structural changes proposed for reorganization included at least two that affected the Administration on Aging: (1) Retaining

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[59a] Congressional Record, Feb. 28, 1978, p. S2536.

[59b] Congressional Record, Feb. 28, 1978, p. S2537.

[60] Many organizations testifying before the Congress on the extension of the Older Americans Act called for the strengthening of AoA in structure as well as staffing. For example, the National Council on the Aging stated at the Subcommittee on Aging hearings on February 8, 1978, that "as just one small part of the Office of Human Development Services. AoA is hardly in a position to affect programs run by other offices of HEW let alone influence the array of employment, housing, transportation, and financing programs outside of HEW's sphere. (Even AoA's limited position has been seriously weakened by the Administration's decision to delay filling vacant positions.)"

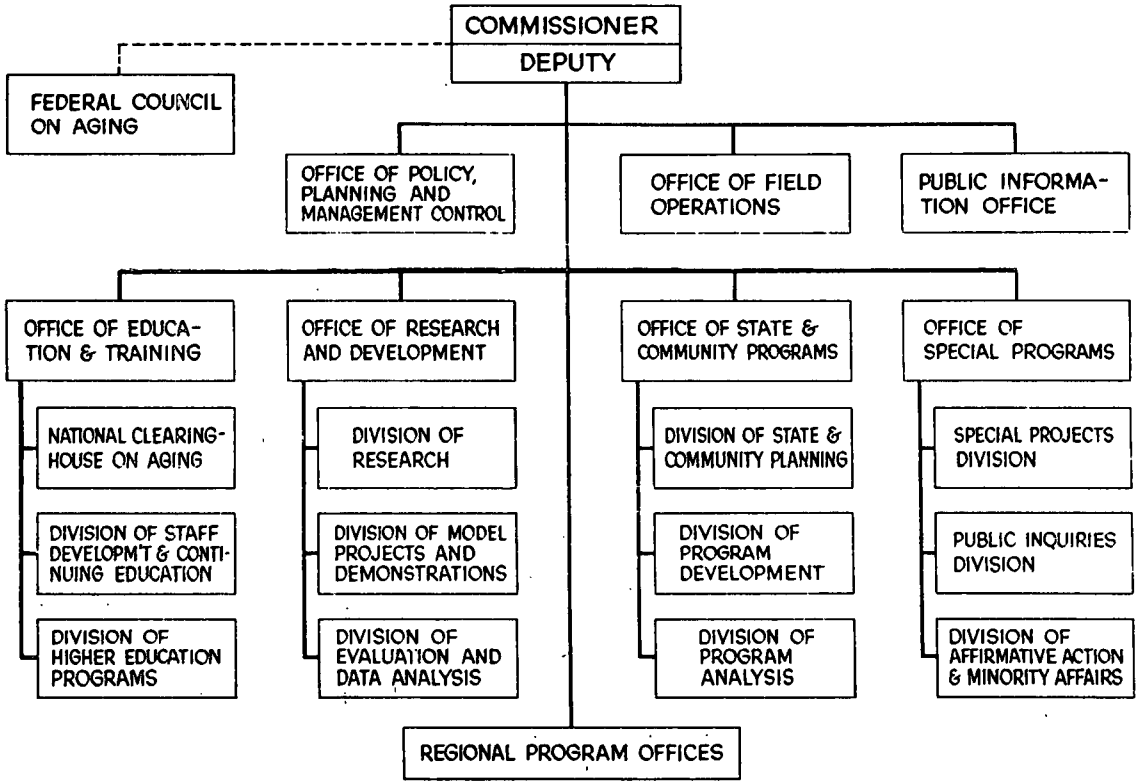
At their spring meeting in Washington, D.C. in February 1978, the National Governors Association commented that the "funding and staffing of AoA must be established and maintained at a level adequate to assure the effective and consistent discharge of its grants administration and advocacy responsibilities."

For additional discussion of staff needs and effects of the proposed OHDS reorganization, see pp. 156–158 of this chapter.

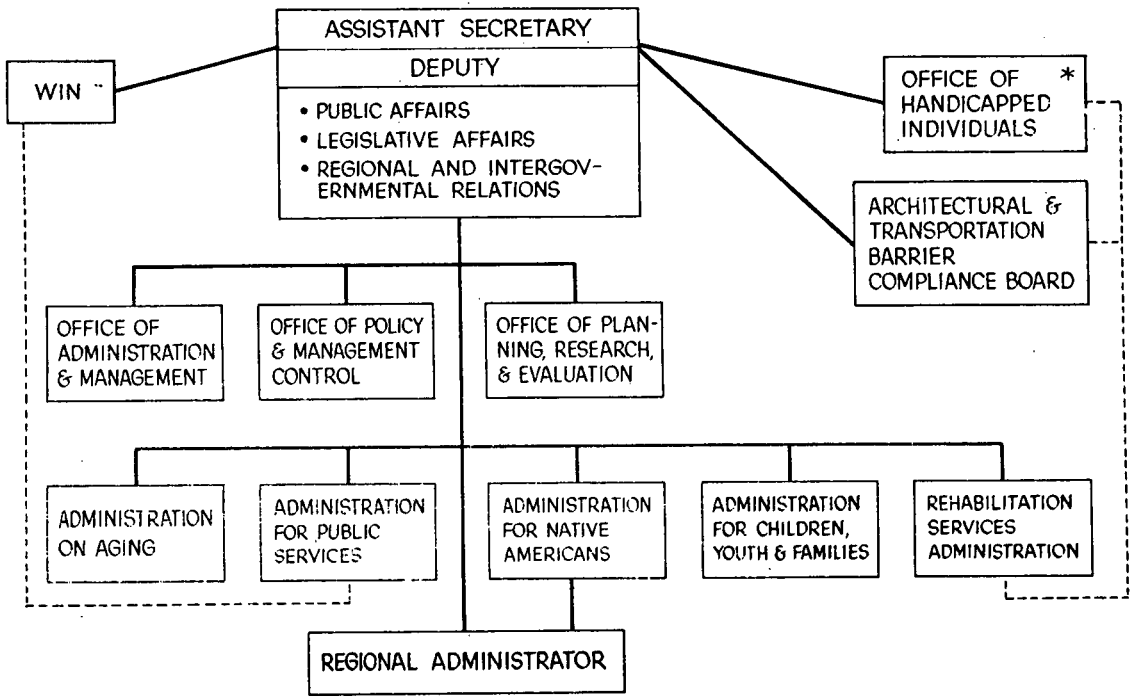
AoA as a subagency under the umbrella of OHDS, and (2) creating several new offices within the central office of AoA.

The charts reflect these structural proposals and list the new offices to be created within the AoA. Several of the "new" offices within AoA would include the public inquiries division, the placement of program development and analysis under the Office of State and Community Programs, the division of evaluation and data analysis and the division of staff development and continuing education.

ADMINISTRATION ON AGING



OFFICE OF HUMAN DEVELOPMENT SERVICES



*Legislative changes will be sought to eliminate the need for a separate OHI reporting directly to the Assistant Secretary. Functions would be lodged in RSA, Office of Advocacy & Coordination.

III. "COMPLETE OVERHAUL," PRIORITY TARGETING, OR INCREMENTAL ADJUSTMENT?

Decisions on issues such as those discussed in the preceding section would be difficult enough even without larger questions looming over this year's deliberations on the Older Americans Act.

But one such consideration becomes more and more apparent as the Congress nears action on that legislation:

Even though most witnesses thus far have proposed varying degrees of the aforementioned "fine tuning"—or significant but not drastic adjustments in "network" operations—calls for more far-reaching change also are heard.

A. The Benedict Proposals

As the final witness last August 3 at a hearing on "Older Americans Programs Oversight" by the House Select Committee on Aging, Robert C. Benedict made what he called "The Case for Complete Overhaul."

His perspective at that time was that of Commissioner for the Pennsylvania Office for the Aging in the Commonwealth's Department of Public Welfare. His testimony was recently cited [61] as a major factor leading to his appointment in 1978 as U.S. Commissioner of Aging.

Mr. Benedict described a rapidly growing percentage of the elderly population which has been called the "frail elderly" by the Federal Council on the Aging, but which he describes as "functionally disabled," or found impaired ability to function in one or more respects which limits one's capacity for independent living."

Commissioner Benedict added:

> Another important fact about the elderly population is that an increasing proportion of the elderly will be very old, that is, over 75. In 1977, 38 percent of our elderly population is over 75. By the year 2000 it will be 43 percent. This means there will be between 12 million and 13 million persons in this country over the age of 75. By the year 2030, that may increase by more than half. There is a very high correlation between advanced age and increased functional disabilities. Among those people not in institutions 65 and over, studies indicate that about 14 percent are either bedfast or housebound. From available data it is possible for us to project that there may well be, in the United States today, between 4 million and 4½ million older persons in need of special assistance. One million of these persons are now in nursing homes, homes for the aged, and other institutions.

Challenging "talk about looking to income as a sole solution for the needs of older persons," Mr. Benedict said:

> The basic fact about aging itself should make it clear to all of us that income alone is not sufficient to ameliorate the basic problems that older people have; and that we also need

[61] By Arabella Martinez, Assistant Secretary for Human Development, Department of Health, Education, and Welfare, at Mr. Benedict's swearing-in ceremony, Feb. 16, 1978.

a fundamental human services strategy if we want to provide them with a way to stay in their own home.

Mr. Benedict's strategy called for a two-tiered national social policy:

> The first part of that policy is one which would address the broad needs of all older people. Such things as the attack on mandatory retirement. Such things as the need to open up all of our educational institutions. Such things as making transportation more accessible. . . .

He, as well, urged special attention to a tier decline with "the problems of a subpopulation of older people who are very old, who are poor, who are disabled, and who are without assistance."

A major obstacle to the development of this two-tier approach is what Mr. Benedict described as "a literal morass of Federal laws and regulations of a number of different conflicting varieties which makes it extremely difficult even for a State which chose to set up a comprehensive service system would find it difficult to do so with the labyrinth of Federal laws and Federal regulations that they have to put up with."

Drawing from his own experiences in Pennsylvania, Mr. Benedict said:

> We have managed to combine title III, title VII, title XX (social services under the Social Security Act), title IX, title V, and some State funds into a single pot of funds to make available to local communities for comprehensive services for the aging, but I would not want to recommend to many other people the kind of pain we had to go through to get that job done.[62]

As outlined at the August hearing, Commissioner Benedict's "complete overhaul" of the Federal "network" drew heavily from the Pennsylvania innovations. He urged: Establishment of "a decent base of comprehensive community-based long-term services which will keep frail older people in their communities," [63] and recognition of the community as the logical base for determining local action priorities and carrying them out:

> I am not sure that our existing local governmental structures are up to the job. Perhaps the Congress should create incentives which would encourage the States to establish new local human service authorities not unlike those which exist to manage our public school systems, to manage human services programs.

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[62] For detailed testimony on one effort to develop such a community base for services to homebound and other elderly, see testimony (pp. 158-63) by Peter D. Archey, executive director of the Berks County, Pa., Office of Aging, at a hearing, "Health Care for Older Americans: The 'Alternatives' Issue," before the Senate Special Committee on Aging, May 17, 1977, Washington, D.C. One of Mr. Archey's advantages, as indicated in his testimony, was: "The Pennsylvania Office on Aging made a critical decision to implement the area agency legislation by utilizing county governments as the single local unit responsible for annual community plans for titles II and VII of the Older Americans Act, title XX of the Social Security Act, and State and local appropriations. This State-level decision has produced a practical, integrated funding philosophy and operation without necessity of any Federal waivers. Pennsylvania also allocated significant title XX funds for the elderly and provided State appropriations for the majority of non-Federal match. Individuals and services covered under title XX are so reimbursed. Services or individuals not eligible or individuals not wishing to voluntarily provide title XX financial eligibility information are covered with funds from title III, title VII, State funds, or a variety of local funds. These services are then related primarily to client need rather than to income level. While emphasizing target priority groups, rich and poor, can be served by unified programs."

[63] A concern and goal later reiterated at his confirmation hearing before the Senate Committee on Human Resources, Feb. 7, 1978.

Mr. Benedict also called for significant alteration of the basic concept of area agencies on aging:

> They (the area agencies) do not have the authority, they do not have the capacity, to foster or manage change in the magnitude required to service 1 American in 10 today and by 1990, one American in eight. We do not need 600 or 700 limited planning agencies. We need a system of between 2,000 and 2,500 comprehensive human service agencies responsible for managing all long-term services for the aged and adults and directly accountable to local communities.

He also called for revisions in current State and area agency planning procedures under the Older Americans Act and asked for fundamental redirection of social service policies toward the aging "going far beyond simple amendments to the Older Americans Act."

His statement concluded:

> Our society has the know-how and the capacity to provide a better life for older people. The critical question is whether or not we have the collective will and the political leadership to make this a top priority and to devote the resources necessary to make it possible.

B. The Binstock Call for Selective Priorities

Another witness at last August's House committee hearings—Dr. Robert H. Binstock, director of the program in the economics and politics of aging at Brandeis University, Massachusetts—became the leadoff witness at the February 1, 1978, hearing on extension of the Older Americans Act before the Subcommittee on Aging, Senate Committee on Human Resources.

Dr. Binstock asked for "a bold strategic departure needed to move the Older Americans Act from an initial phase—12 years of agenda-setting and bureaucratic development—to a second phase of problem-solving."

Acknowledging that the Older Americans Act has provided direct help to many older persons and that it has brought forth legitimate public concerns such as the need for home care services and convenient transportation while developing a network, Dr. Binstock said that the strengths of the act go "hand in hand with a series of weaknesses."

Among the deficiencies identified by Dr. Binstock:

—Funding distribution so thin as to have little impact on any given problem.

—The "illusion" that a variety of problems can eventually be solved through funding an implementation under the Older Americans Act.

—The bureaucratic components of the network—the public and voluntary service agencies and the universities and the colleges—have quite understandably become preoccupied with sustaining and expanding the different, thinly funded program elements with which they are directly involved.

Dr. Binstock asked for a legislative approach that eliminates such compartmentation in favor of consolidating funds available at the local level:

> Each community would receive its total formula allotment of funds as at present. But, working through its area agency, each community would be required to make a priority decision for using those funds, in order to have a substantial impact upon the most extreme problem confronted by older persons in that community. The legislation would not provide restrictions as to categories of priority other than the extensive agenda of legitimate general concerns that has already been elaborated. Rather, it would provide that most of the funds available, somewhere between 80 and 90 percent, be expended by each area for a priority program in accordance with its perception of the most pressing local concern related to the needs of older persons.
>
> Perhaps this general approach would make it possible to have an impact on at least one problem of importance in each community. It would certainly be better than the current situation in which only a little effort is put into a great many problem areas, and a tremendous amount of energy is being expended upon issues of professional and industrial domain and stature.

Senator Thomas Eagleton, chairman of the Subcommittee on Aging, followed the Binstock testimony with many questions, directed to program directors and others associated with the Older Americans Act, as to adequacy of current efforts. He received many acknowledgements of frustration caused by funding inadequacies and by Federal requirements which appeared to be irrelevant in the face of acute community needs.

One response to the Binstock approach was offered by Mr. Benedict at his confirmation hearing.

Asked by Senator Eagleton whether it would be better to do "fewer things more intensively than trying to do so many things meagerly," Mr. Benedict drew an analogy to community goals for local school systems:

> In a way it is sort of like saying . . . we have only so much funds; do we want to teach first grade children how to read; do we want to teach high school seniors physics; do we want to teach college freshmen literature, postgraduate students research methodologies?
>
> I'm afraid that what we are talking about is providing a set of services that relate very basically to quality of life, an ability to live decently. Except for a willingness to suggest that the local agencies ought to concentrate their planning, their coordination and the commitment of their resources to the notion of keeping people out of institutions, to the notion of keeping them in their own homes free and independent, I would be reluctant to suggest to any community that it

had to make that awful choice in such dramatic terms: all transportation, all in-home services.

These are very difficult things we are talking about, and I find them repeated, Senator, at every State advisory committee meeting, at every meeting of local area agency advisory boards, because what I find these people understanding is that they are not so much deciding who is going to get served as they are making the awful decision about who is not going to get served.

C. Incrementalism? At What Pace?

Administration proposals to extend the Older Americans Act have not, at this writing, been received by the Congress; and it is not known whether Commissioner Benedict's thinking on "overhaul" will be adopted or adapted, or whether some version of Dr. Binstock's priority-setting would be taken.

Most witnesses at hearings and workshops held thus far, however, appear to favor an incremental approach building upon the structure already in place.

But it was also clear that many witnesses were impatient at the rate of improvement.

QUESTIONS ABOUT FUNDING

Few outright proposals for major increases in funding were made by witnesses at Older Americans Act hearings in 1977 and 1978;[64] perhaps because of steady and significant gains in appropriations for Older Americans Act programs in recent years, or perhaps because of uncertainty about Administration plans.

The Urban Elderly Coalition, however, raised questions about the adequacy of Administration budget proposals for the Older Americans Act. In a statement presented to the House Budget Committee on February 8, 1978, the coalition offered a table which it said showed percentage decreases in OAA funding when adjusted for inflation and the increase in numbers of elderly to be served.

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[64] Among the exceptions: John W. Anderson, chairman of the National Association of title VII Project Directors, asked for an increase of 100 percent in the title VII funding level for fiscal year 1979, with "additional minimal increases of 25 percent of the funding level of the previous year's allocation for fiscal year 1980 and an additional minimal increase of 25 percent of the previous year's allocation for fiscal year 1981. In testimony before the Senate Subcommittee on Feb. 7, 1978, he added: "This recommendation is made in light of the fact that although title VII programs serve in excess of 400,000 older Americans daily through direct services and that an actual waiting list of 800,000 older Americans still exists."

Another request related to funding was made at the Senate hearing in February by Gerald A. Bloedow on behalf of the National Association of State Units on Aging. He gave examples of increased responsibilities given by Governors and State legislatures to such units, and said that these advances were heartening. But he added:

"The facts are clear: recent increases in State administrative funds have simply not kept pace with the accelerating Older Americans Act programs: In fiscal year 1975, States were provided with $15 million to manage a program of just over $200 million. By fiscal year 1977, States were asked to manage a program approaching $350 million with only $17 million in administrative funds. In fiscal year 1978, State program dollars are well over $400 million, and only $19 million has been provided in Federal funds for administration."

Mr. Bloedow said that NASUA urged the committee to ensure more adequate funds for administration.

NET INCREASES/DECREASES IN EXECUTIVE BUDGET FOR OAA FROM FISCAL YEAR 1978 TO FISCAL YEAR 1979[1]

[In millions of dollars]

	1978 appropriations level	1979 executive budget request	1978 base plus 6.8 percent inflationary adjustment	Net difference from executive budget	1978 base plus 6.8 percent inflationary adjustment plus 2 percent increase in eligible client group	Net difference from executive budget
Title II	2.45	2.45	2.62	−0.17	2.67	−0.22
Title III	187.00	187.00	199.73	−12.72	203.71	−16.71
Title IV	29.30	29.30	31.29	−1.99	31.92	−2.62
Title V	40.00	40.00	42.72	−2.72	43.57	−3.57
Title VII	250.00	[2] 250.00	267.00	−17.00	272.34	−22.34
Title IX	190.40	[3] 190.40	203.43	−12.94	207.41	−17.01
Total	699.15	699.15	746.70	−47.54	761.62	−62.47

[1] Testimony submitted to House Budget Committee Task Force on Community and Physical Resources, and Task Force on Human Resources, Feb. 8, 1978.
[2] Not included is the $37,000,000 transferred from USDA commodities which is not an actual dollar increase to the program.
[3] The administration will seek an authorization level of $228,450,000.

The UEC estimated that an additional $62.5 million would be needed if the 1979 population is to be served at the same level as the 1978 population by programs administered under the Older Americans Act. Another $67.5 million, according to UEC would be needed "to allow for at least a 10 percent for services directed to maintaining the functionally disabled elderly in their homes and communities."

On the area agency level, frustration at funding limitations is often expressed.

Leon Harper, director of the Los Angeles County Area Agency on Aging and president of the board of the National Association of Area Agencies on Aging (N4A), said at the February 3 Senate hearing:

> While we have had increased resources in programs serving the elderly, we have not seen fit to expand the capacity of the area agencies accordingly. Instead, the Older Americans Act has limited their capacity to expand commensurate with their increasing responsibilities. Administrative resources remain fixed at 15 percent of the title III funds which the area agency administers. At the same time, area agencies are responsible for administering increased service funds for the elderly.

He gave the following examples:

> 1. The Seattle-King County Area Agency receives $673,000 title III funds but is responsible for administering an additional $2,865,000 from other sources. They indicate a problem with the 15 percent limit on administrative funds.
>
> 2. The area agency in Lewiston, Idaho, receives $82,000 title III funds but is responsible for administering an additional $335,000 from other sources. They indicate a substantial difficulty with the 15 percent limit on administrative funds.
>
> 3. The area agency in Indiana, Pa., receives $95,000 title III funds but is responsible for administering an additional $450,000 from other sources. They indicate substantial difficulty with the 15 percent limit on administrative funds, and finally,

4. The area agency in Shreveport, La., receives $303,000 title III funds but is responsible for administering an additional $634,000. They indicate a major hardship with the 15 percent limit on administrative funds.

Mr. Harper also said that the Administration on Aging has been given other responsibilities—including work with legal service projects and help in initiating ombudsman activities—without additional administrative and planning resources.[65]

QUESTIONS ABOUT REPORTING AND ACCOUNTABILITY

One of the arguments made in support of increased administrative funding for area and State agencies is, as reported in the previous section, the increased responsibilities given to those agencies under the Older Americans Act and through the "tapping" of other programs.

A new General Accounting Office report, "Actions Needed to Improve the Nutrition Program for the Elderly" (February 23, 1978), dealt with accountability problems in the title VII program. It questioned the effectiveness of the Administration on Aging's information system as incapable of supporting the ongoing management of the program.

Senator Frank Church, in his statement to the Senate Subcommittee on February 1, commented on the significance of the report:

> We are all familiar with the popular title VII nutrition programs, so visible in many communities throughout the country. However, I urge the subcommittee to ask the administration to give more effective assistance to the projects and States in developing better auditing and monitoring procedures for tracking the contributions received from participants in title VII programs. State and project directors elderly participants, and the General Accounting Office have told the Committee on Aging about the need for better control of these funds which, on a nationwide basis, could be as high as $30 million a year. The staff of the Committee on

[65] What Mr. Harper described as "unwritten coordination and pooling activities" initiated by AAA's often go beyond resources available from any one progrram. Among the examples he gave: "In Des Moines, Iowa, the area agency, as a prime mover, began working 2 years ago with the Association of Local Governments, City, County, Metropolitan Transit Authority, cab companies, private nonprofit agencies and the State department of transportation, to form a special transit service for the elderly and the handicapped. Transportation services were so fragmented with over 30 agencies providing their own services. Last summer, through a series of intergovernmental agreements and contracts, the agencies turned over the operations of their vehicles to the Metro Transit Authority. Services are now in place for the elderly and the handicapped. Funds are provided by: Polk Company ($118,000), Community Services Administration ($40,000), title III, Iowa Department of Transportation, Cottage Grove Presbyterian Church, the RSVP program, foster grandparent program, the Des Moines Independent School District, Iowa Methodist Hospital, the city of Des Moines, and the Iowa Lutheran Hospital. In addition, the Polk/Des Moines Tax Payers Association provided the initial forum for the groups coming together. By no means is the project functioning 100 percent effectively. There are still some administrative kinks, but the area agency board has people communicating with a good start at developing a coordinated transportation system. * * *"

"Still another example comes from Delaware County, N.Y. Delaware County is a large rural county in upstate New York where over 20 percent of the population is 60 years of age and over. Nearly 30 percent of those elderly live on incomes below the poverty level. As a result of last year's drastic increase in utility rates, many of these low-income elderly found they could not afford to properly heat their homes. The area agency launched a project to gather and distribute firewood to those older persons who could use wood as a primary heating source. To identify those elderly persons in need of firewood, a publicity campaign was launched through the Kiwanis, Rotary, and Lions clubs. These same service club members processed the firewood into a useable form. Members of the local Boy Scouts of America chapter were then mobilized by the area agency to carry, stack, and distribute the firewood to those elderly who needed it. The area agency negotiated a supply of firewood through an agreement with the New York State Department of Environmental Conservation to do selective cutting in State forests. Private landowners were also contacted and asked to donate their timber to the cause. To expand the supply of timber even further, the area agency is negotiating with the city of New York to do selective cutting on lands surrounding their extensive reservoir system in Delaware County. Other resources tapped in carrying out this project include the local Community Service Administration, the local department of social services, and the Public Health Nursing Service, all of whom have referred elderly persons to the project."

> Aging has made a preliminary analysis of the situation and agree that more effective administrative controls must be developed.

Additional questions about accountability were raised by Carroll Estes,[66] associate professor in the department of social and behavioral sciences at the University of California. She also dealt with AoA reporting problems in testimony before the California Assembly Special Subcommittee on Aging in San Francisco on November 18, 1977:

> . . . the multiplicity of goals and responsibilities assigned by the act—and the vagueries of what is expected in performing each of requisite tasks of planning, pooling, coordination, and advocacy has seriously limited the ability of States to render OAA agencies fully accountable. For example, OAA staff have reported serious concern about the lack of uniform and definitive expectations regarding what constitutes minimally acceptable progress and performance for each of the major intervention strategies within title III *and* the relative emphasis which they should give (a) *between* the many areas of assigned responsibility (e.g., pooling, coordination, services, advocacy), and (b) *within* any one of these strategy emphases (e.g., emphasizing low income or all income elderly in service subcontracting). Such goal complexity and the resultant ambiguity of preferred outcomes have critical ramifications for accountability, and the political vulnerability of OAA agencies to all sorts of criticism. *Without knowing what represents an acceptable performance, how can agencies be held answerable? And, without clearly delimited long and short term expectations, how can the success (or failure) of title III and title VII be substantiated against the claims of its critics?* And without eliminating the range of permissible actions, these agencies are extremely vulnerable to all sorts of goal displacing political pressures (because standards/requirements aren't delimited in any way).

Responding to the growing concern about the "redtape" and paperwork burden, Senators Domenici, Brooke, and Percy included a section in their bill (S. 2609) directing AoA to "continually reexamine the nature and frequency of all agency requests for information."

QUESTIONS ABOUT AOA STAFFING PRACTICES

At Senator Church's request,[67] the General Accounting Office, during 1977, conducted a survey of the assignment of Older American Act staff at regional offices of the Office of Human Development. The GAO report cited concerns of regional office directors who felt that personnel freezes and the press of other duties had seriously reduced the effectiveness of the aging components of the regional offices.

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[66] Dr. Estes is also a former member of the California Commission on Aging and chairman of the public policy committee, U.S. Gerontological Society. An information paper prepared by Dr. Estes for the Senate Special Committee on Aging will soon appear. It will be called: "Paperwork and the Older Americans Act: Problems of Implementing Accountability."

[67] "A Statement of Facts: Information on Staffing of HEW Regional Offices of Aging," presented by GAO to Senator Church, December 1977.

Senator Church, in a letter of December 27 to HEW Secretary Califano, commented on the regional directors' estimates of the situation:

> Their general view that additional staff is needed to perform all duties required of their offices is particularly significant, I think, in view of the many new duties assigned to the Administration on Aging under legislation recently enacted by the Congress, including the establishment of nearly 600 area agencies on aging since 1973 . . . I would appreciate your comments on the GAO report, together with information about adequacy of staffing at AoA headquarters. It is my understanding that 125 slots are authorized, but only 84 are filled. If this is accurate, what are HEW plans to deal with the situation.

Secretary Califano has promised a report.

Another staffing issue was linked during the Senate hearings to the Office of Human Development reorganization (See prior section.)

In his statement for the National Association of State Units on Aging, Mr. Bloedow said:

> At the Federal level, we have watched with dismay the continued erosion of the authority and resources available to the Administration on Aging to administer the Older Americans Act programs. Recent reorganization efforts have clearly enhanced the policymaking and coordinating role of the Office of the Assistant Secretary for Human Development Services while neglecting the long overdue strengthening of the program units. Yet, just a few years ago the Congress and national organizations concerned with older persons strongly supported the removal of AoA from SRS (Social and Rehabilitation Service) in an attempt to strengthen the programs' resources and identification. *The recent steps toward reorganization within OHDS appear to be a major step backward. As a result, the program units will be further drained of the required resources to serve adequately their respective constituent groups—the aged, the disabled, the handicapped, the blind, the young and native Americans.* [Emphasis added.]
>
> NASUA believes that AoA does not now have the resources it needs to fulfill the mandates of the Older Americans Act. Further erosion of AoA's authority, coupled with further reduction in staff (already at inadequate levels for efficient and effective administration of the programs) will create almost insurmountable barriers to the intent of Congress as defined in title II of the Act that AoA should be an effective and visible focal point for aging matters at the Federal level. As a result, AoA will not be able to represent in any meaningful way the interests of older persons in other Federal program, policy, and regulatory decisions that impact on the elderly. And as a result, AoA will not be able to provide the fiscal and program management required throughout the national network on aging. Most importantly, as a result, older

persons for whom the program is designed will be short-changed.

D. Questions Posed By Secretary Califano

Late word on considerations now apparently receiving intensive study at the Department of Health, Education, and Welfare, was provided in the March 20 testimony by Secretary Califano (see introduction to this chapter for details on specific proposals).

Calling for a reexamination of the organization and delivery of services needed to meet the pressing needs of the next decade, the Secretary posed these questions:

> How can we ensure that our systems of support respond effectively to the widely varying circumstances of the elderly and their families? Their needs are as diverse as the communities and families from which they come. We must respect their desires and choices as we design our programs.
>
> How can we make certain that the efforts of Government actually enhance and add to the compassionate care and support of families for their elders? We have become aware that in some cases, Government's interventions may strain rather than strengthen family life.
>
> How can we halt the fragmentation, waste, and duplication which have come with the great proliferation of programs for the elderly at every level of Government? The cry one hears from States and communities is for a basic sorting of responsibilities, a drastic reduction of paperwork, and for simplification of rules and regulations which seem to construct barriers for communities, rather than open opportunities for them.
>
> How can we build a partnership with State and local governments to improve the management and delivery of services to the chronically impaired?
>
> How can we be sure that federally supported programs do not upset existing services for the elderly? We have found, to our dismay, that the entrance of a Federal program into a community sometimes causes the exit of other programs—especially some volunteer efforts.
>
> How can we build incentives into our system of care that will encourage the least restrictive care in each case? And how can we guarantee the right of elderly citizens to choose their own alternatives?
>
> By what mechanism shall an individual's needs be measured—or a provider's services be rated?

FINDINGS AND RECOMMENDATIONS

The value and growing importance of the Older Americans Act have been amply demonstrated during its more than 12 years of existence.

Nearly 560 area agencies on aging have been established in jurisdictions where 92 percent of the aged population live. Older Americans receive a wide range of services under the title III

State and community programs on aging, including transportation, legal counseling, home health, homemaker, escort, residential repair, information and referral, and others.

The title IV program responds to one of the most critical problems in the field of aging: The need for more adequately trained personnel to deliver essential services for older Americans. In academic year 1977–78, nearly 890 students in 57 institutions received financial assistance under the title IV–A training program for careers in gerontology. Title IV has helped to stimulate interest for careers in gerontology. Almost 19,000 individuals have enrolled in college and university gerontology courses. Nearly 140,000 persons have received short-term training in a wide range of settings.

The title V program makes it possible for elderly persons to obtain a wide range of services effectively and efficiently in one location. Funding in fiscal year 1979 will be used to (1) renovate or alter fully or partially 2,340 multipurpose senior centers, and (2) acquire 260 facilities to be used as centers.

The title VII national hot meals program has been enormously effective for older Americans. Nearly 578,000 nutritious meals will be served daily at the end of fiscal year 1978 at 10,200 senior centers, schools, churches, and other nonprofit settings. In addition, the program provides an opportunity for elderly persons to meet and talk with others. Quite frequently, this socialization function is as important as the meal itself.

The effectiveness of the Older Americans Act has been documented time and time again. But a compelling need exists to expand the act to give priority attention to persons who need practical help to live independently in their homes.

The committee recommends that the Older Americans Act be extended for at least 3 years with increased authorizations. This should be followed up by increases in appropriations levels.

In addition, the committee recommends that:

—Congress should improve coordination among titles III, V, and VII by adopting a complete or partial consolidation directing enhanced administrative efficiency and service delivery effectiveness.[68]

—Greater emphasis should be placed under the act upon in-home services, including home health, homemaker, chore services, home-delivered meals, and escort services.

—Legal services and the nursing home ombudsman programs should receive increased support and new emphasis. Efforts should be initiated to coordinate the activities of attorneys, paralegals, nursing home ombudsman, and others with all programs in the aging network.

[68] On Feb. 28, 1978, Senators Pete V. Domenici, Edward W. Brooke, Charles H. Percy, and others introduced S. 2609, which would consolidate titles III and V while leaving title VII separate. The measure would however, strengthen the coordination between the expanded title III and title VII. Senator Church has recommended that titles III, V, and VII be consolidated with separate authorizations for each program. In his testimony before the Human Resources subcommittee on Aging on February 1, 1978, he said: "The Older Americans Act has now evolved to the point where it is practical to consolidate the services titles—III, V, and VII—into one title, while retaining the separate authorizations for each program. This would make it possible to permit a second administrative improvement: a single State plan for the Older Americans Act. As things now stand, State units on Aging submit several plans; one for Title III services, another for Title V senior centers, and still another for the Title VII nutrition program. My proposal would not only eliminate this burdensome paper work, but it would also permit better coordination of programs."

—Funding should be authorized for staffing of multipurpose senior citizens, but overall emphasis should continue to be placed upon the acquisition, alteration, or renovation of facilities to be used for senior center purposes.
—Limited construction should be authorized when it is not possible to acquire, renovate, or alter existing facilities to be used as senior centers.
—Direct funding be authorized for Indian tribal organizations.
—A national manpower policy on aging should be established to direct the career and short-term training efforts under the Older Americans Act.
—The Administration on Aging should be moved out of the Office of Human Development Services and made directly responsible to the Secretary of Health, Education, and Welfare.
—Uniform standards be applied throughout the Older Americans Act to assure that low-income and minority elderly persons are effectively served.
—A White House Conference on Aging should be held no later than 1981.

Moreover, senior centers—in order to fulfill their increasingly important function as a focal point for the delivery of services—should receive special attention in the administration initiatives planned for announcement and discussion by Secretary Califano in 1979.

Another matter which should receive intensive attention in the Administration considerations is the role of the Older Americans Act in developing a community base for in-home and other non-institutional services needed by growing numbers of older Americans who have one or more chronic disabilities.

CHAPTER IX

AGE DISCRIMINATION STUDY AND RECOMMENDATIONS

". . . no person in the United States shall, on the basis of age, be excluded from participation in, or be denied from benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance."

—Age Discrimination Act of 1975 (Public Law 94–135).

". . . we have given special consideration to the impact of age discrimination in the delivery of federally supported services and benefits on the lives of older persons. We are shocked at the cavalier manner in which our society neglects older persons who often desperately need certain federally supported services and benefits."

—U.S. Civil Rights Commission, in "The Age Discrimination Study," December 1977.

Congress, when it enacted the Age Discrimination Act of 1975, decided to hold off all-out implementation of its major provisions until it could obtain more information about possible pitfalls in the path of reform.

Representative John Brademas, chairman of the House unit[1] which considered the legislation, has given the following account[2] of the reasons for deciding to conduct a study before taking direct action to end what was described as "unreasonable discrimination" based on age in programs and activities receiving Federal financial assistance:

. . . This law, like most laws that chart new legislative territory, was the product of compromise. My House colleagues and I were persuaded that age discrimination was a serious and shameful problem and that it should be prohibited immediately. Our Senate colleagues agreed that there was a problem, but they were troubled by the unanticipated dangers that might exist in the uncharted territory to which we were forging.

The outcome of our deliberations was the creation of a multistaged process. We set forth immediately the principle of nondiscrimination on the basis of age. We provided for the study which the [Civil Rights] Commission is now conducting,

[1] Subcommittee on Select Education, House Committee on Education and Labor.
[2] In testimony before the U.S. Civil Rights Commission, Sept. 26, 1977, as cited in the Oct. 6, 1977, Congressional Record (p. E. 6170).

and finally, we delayed enforcement of the prohibition against age discrimination in federally assisted programs until January 1, 1979.

The study to which representative Brademas referred, as assigned to the Civil Rights Commission,[3] was completed in December 1977 and released on January 10, 1978.

Its major finding was that children and older persons are being denied access to federally supported services and benefits on the basis of age and that this in turn is having a serious adverse impact on their lives.

Another conclusion is that *all* denial of access by administrators to federally supported services and benefits to programs on the basis of age are "unreasonable" and should be prohibited by law.

The report issued recommendations which were considered by the Brademas subcommittee at a hearing in January. They will receive additional congressional scrutiny in a process intended to help the Secretary of Health, Education, and Welfare to formulate reasonable and workable regulations before the January deadline for action.

I. THE MANDATE AND THE RESPONSE

Public Law 94–135, the Age Discrimination Act of 1975, states:

> The Commission on Civil Rights shall (1) undertake a study of unreasonable discrimination based on age in programs and activities receiving Federal financial assistance; and (2) identify with particularity any such federally assisted program or activity in which there is found evidence of persons who are otherwise qualified being, on the basis of age, excluded from participation in, denied the benefits of, or subjected to discrimination under such program or activity. . . . Not later than 18 months after the date of enactment of this act, the Commission shall transmit a report of its findings and its recommendations for statutory changes (if any) and administrative action, including suggested general regulations, to the Congress and to the President and shall provide a copy of its report to the head of each Federal department and agency with respect to which the Commission makes findings or recommendations.

In July 1976, the Commission began its study and posed five major questions as guidelines:

—Does age discrimination exist in programs or activities receiving Federal funds?
—Which individuals or groups are affected?
—What policies or practices cause or lead to age discrimination?
—What reasons are given to justify the discriminatory policies, practices or results?
—What actions are necessary to address the problems identified?

The Commission chose 10 Federal programs for analysis: Community mental health centers, legal services programs, basic vocational rehabilitation services, community health centers, social services to

[3] The U.S. Commission on Civil Rights is an independent, bipartisan, fact-finding agency established by the Congress in 1957. Current members are Arthur S. Flemming, Chairman; Stephen Horn, Vice-Chairman; Frankie M. Freeman; Manuel Ruiz, Jr.; and Murray Saltzman.

individuals and families (title XX), training and public service employment programs, food stamp program, medical assistance program (medicaid), State vocational education basic grant programs, and adult basic education programs. In each case, the Commission collected data and information in the form of Federal and State statutes and regulations, budget documents, program statistics and findings from reports and research studies. Supplementing the data collection were interviews with persons with special expertise in the programs, including Federal, State, and local program officials, and service planners and providers.

These studies and interviews were complemented with field hearings in San Francisco, Denver, Miami, and Washington, D.C.

Witnesses told the Commission of age discrimination, conscious or otherwise, within their agencies or departments.

A regional health administrator from San Francisco said:

> I believe that our emphasis on prevention has in good measure been targeted at the younger age groups. It has been targeted to children. Its been targeted at mothers. It's both in the medical area as well as in dental care. It does not represent any exclusion of service to the elderly. . . . it is just our belief that the payoff is a little better the younger you have intervention through preventive activities.[4]

The Civil Rights report commented:

> This statement appears to overlook the importance that early detection and prevention of illness have for persons of *any* age. Today's older persons have much to gain from preventive health care services. The "payoff" that results may be equally important to society, both economically and socially. Interpreting such a universally applicable phrase as "preventive health care" to apply primarily to a narrow age segment of the general population effectively diminishes the opportunity of other age groups to receive such care. (Emphasis added.)[5]

Several witnesses said that many of their program personnel refer to a YAVIS formula when selecting clients or patients. YAVIS is defined as Y is for young, A is for attractive, V is for verbal, I is for intelligence, and S is for successful or self-serving.

A letter from the President of the Legal Services Corporation pointed out to the Commission that "*Every* group of poor persons—not just the elderly—receives inadequate legal services because of inadequate public funding."

The Commission report observed:

> The Commission acknowledges the problem of resource scarcity in legal services, but questions whether one age group should have to bear primarily the effect of scarce resources.[6]

Making a more general observation, the report later challenged the view that older persons should receive low priority in allocation

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[4] "The Age Discrimination Study," a report of the U.S. Commission on Civil Rights, December 1977, p. 27.
[5] Page 28 of report cited in footnote 4.
[6] Page 48 of report cited in footnote 4.

of services or benefits because resources are too limited to meet the needs of all persons. The Commission said:

> Resources are always limited. Program administrators may be unable to serve all eligible persons and therefore must set priorities. Priorities should not be established, however, by using age as a criterion for denying access to needed services. Other criteria based on an evaluation of the relative needs of individuals are always available. The fact that they may be more difficult to administer does not constitute a sufficient basis for rejecting them.[7]

The term "employable" was defined by the director of Colorado's Special CETA grant program as those persons that "industry will pick up on" and "put to work once the recession fades." He suggested that this meant workers in the age brackets of 22 to 44.[8]

The director of social services in Denver explained that the decline in services to older persons in that city came about because nearly all of the available staff had been assigned to child abuse and neglect cases.

Lack of adequate outreach was given as the reason for low participation by older persons in the community health center programs in the San Francisco area.

And, finally the director of the Colorado State Mental Health Association described an obstacle, often cited at the hearings, to serving special interest groups. That is, even though it is understood that the centers are required to serve all age groups, the persistent problems of personnel shortages, limited resources and preferences for treating young adults militate against any real change in the provision of services to children and older persons.

II. REPORT FINDINGS

The Commission grouped its findings by method of discriminatory practice. The major categories:

1. Discrimination on the basis of age in the delivery of federally supported services and benefits exists to some extent in each Federal program examined.

Example: Community mental health centers reported that in 1975, 328 mental health centers reported the addition of 539,947 persons to their caseloads. When reviewing the age distribution of the new patients, the Commission found:

Age Group	Service area population (percent)	Patients (percent)
All ages	100.0	100.0
Under 15	28.8	16.3
15 to 24	18.1	26.1
25 to 44	23.1	38.4
45 to 64	20.1	15.1
65-plus	9.9	4.1

Source: U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Biometry and Epidemiology, unpublished data.

[7] Page 79 of report cited in footnote 4.
[8] Page 28 of report cited in footnote 4.

The low rate of participation by persons 65 and older was not due to a low rate of mental illness among that age group. In fact, according to the Center for the Study of Mental Health of the Aging of the National Institute of Mental Health, 18 to 25 percent of persons 65 or older have mental health problems that interfere severely with their ability to function on a daily basis.

Example: Upon examination of the data of prime sponsors for CETA (Comprehensive Employment and Training Act) and unemployment rates, the staff of the Commission found that in fiscal year 1976 data shows the marked age disparities in program participation under titles I, II, and VI of CETA.

Age group	Unemployed population [1] (percent)	Title I enrollees [2] (percent)	Title II enrollees [2] (percent)	Title VI enrollees [2] (percent)
All ages	100.0	100.0	100.0	100.0
Under 19	17.1	35.9	4.4	4.6
19 to 24	16.5	20.9	17.6	17.4
22 to 44	46.5	36.4	64.1	64.2
45 to 54	10.9	4.0	8.9	8.7
55 to 64	6.8	1.9	4.2	4.3
65-plus	2.1	.8	.8	.8

[1] U.S., Department of Labor, Bureau of Labor Statistics, unpublished data.
[2] U.S., Department of Labor, Employment and Training Administration, unpublished data.

The Commission asserts that these figures probably understate the actual situation because persons 65 and older are not accurately accounted for in the data on unemployed persons.

2. Members of minority groups, women, and handicapped individuals are often victims of compounded discrimination based on age, sex, race, national origin and handicap.

Example: The Deputy Regional Health Administrator for the U.S. Public Health Service in Denver testified:

> Cultural barriers, particularly for the minority aged, are a significant barrier to utilizing health care. Particularly because the cultural difference tends to be accentuated in the aged, the degree of acculturation tends to be less, and, therefore, the health care institutions tend to be more alien and perceived as being less useful or compatible with the person's needs as he defines them culturally.[9]

The report said that program administrators are not taking adequate steps to take into account the multiple problems faced by many older persons and to increase their opportunities for services and benefits.

3. Age discrimination exists because Federal, State, and local program administrators develop policies that narrowly interpret broad statutory goals, the application of which limits the participation of certain age groups.

Example: Preventive health care standards of community health centers are usually directed at children, youth, and young adults. In fact, the U.S. Public Health Service's "forward plan for health" for fiscal years 1978 through 1982 devotes nearly all of its plans for preventive care to the needs of the young.

[9] Page 24 of report cited in footnote 4.

Example: The goal of the vocational rehabilitation program is rehabilitation of handicapped individuals for gainful employment. Therefore, the program's emphasis on competitive employment joined with the poor employment prospects for persons of certain ages, effectively restricts the application of this program to persons under 45 years of age.

4. Age discrimination takes place when Federal Government establishes program performance standards which effectively restrict participation to certain age groups in the program.

Example: Commission staff found that upon site visits to CETA prime sponsors, program administrators were found to "cream" applications for potential CETA slots. "Creaming" applies to choosing applicants who are job-ready and easier to place in unsubsidized employment. That is, screening out of those applicants who most likely would face serious employment barriers.

Example: The evaluation standards of the State vocational rehabilitation programs set levels of performance in placing handicapped persons in different types of gainful employment—70 percent for competitive employment; 6 percent in noncompetitive employment; and 18 percent in homemaker status. These standards have resulted in accepting cases involving the young and placing of older persons in homemaker positions. However, several administrators pointed out that they were having to reduce the number of homemaker placements and transfer those slots to competitive employment placements.

5. Age discrimination occurs whenever State legislatures convert a Federal program intended to serve all age groups into categorical programs for specific age groups.

Example: Title XX was enacted by the Congress as a social services program for low-income persons, with States having the discretion to develop individual services plans. The Commission staff found that often State legislatures passed laws which call for a specific age group program without appropriating State funds for implementation of the program. Therefore the States utilize their title XX allocation for such a program and therefore reduce their potential to serve other age groups.

6. Young persons' access to mental health services is restricted by State laws requiring parental consent as a condition to receiving services.

Example: Many States have passed State statutes prohibiting treatment by community mental health centers to persons below the ages of 18 or 21 without parental consent. This has resulted in the centers inability to provide treatment for drug abuse, alcoholism, and other mental health problems to young persons.

7. Age discrimination takes place when, without express authorization in Federal statutes, State and local program administrators develop program policies or practices that in effect restrict participation to certain age groups.

Examples: Title XX, CETA, and vocational rehabilitation often define their eligible population for their programs and the services to be provided in a manner that is restrictive to certain segments of the population. In one State, counselors are directed to consider whether the applicant will remain employed long enough to justify service expenditures. Counselors are to use this criteria especially when screening individuals at the "upper end of the age scale."

8. Continuance of historical patterns of age discrimination in the allocation and use of funds for service programs is justified by some Federal, State, and local administrators on the grounds that more equitable allocation requires additional funds.

Example: State administrators of title XX are reluctant to cut back funding from one specific age or interest group to give to another. Therefore, the funding of a program is often perpetuated on the basis of previous support and not on the effectiveness and demand for the program.

The director of the Colorado State Department of Institutions' Division of Mental Health pointed out that early days of the community mental health centers the programs were focused on the needs of the adult population. It has been difficult to overcome the traditional programs and provide assistance to children and to the elderly.

9. Age discrimination takes place when program administrators contract for the provision of services with agencies and organizations that place age limitations on the services they provide.

Example: Administrators of State CETA title I programs told the Commission staff that State labor laws often have minimum age requirements. Therefore, CETA slots available in those areas are governed by those restrictive guidelines. The same may be true of agencies and organizations which receive title XX contracts. Their agencies often have age requirements for participation and therefore they restrict their applicants on the basis of their own requirements and not those of title XX.

10. The failure of public and private administrators to institute outreach programs designed to inform eligible persons of available services results in age discrimination.

Example: The Commission found that even though Federal food stamp program regulations specify outreach programs for the special needs of the elderly, disabled, migrants, rural residents, and other ethnic groups, such efforts often are minimal. Persons who are homebound and isolated and presumed to be eligible for food stamps, never even learn of the program, let alone about their potential eligibility.

Example: The director of the San Francisco Medical Center outpatient improvement program noted that the lack of outreach has a particularly negative effect on older persons because of their lack of mobility and difficulty in getting to the centers.

11. Age discrimination results when program administrators rely on referral sources that are ineffective in reaching all age groups.

Example: Medicaid, food stamps, and title XX social services all have ties to the offices which determine and administer the cash assistance programs—aid to families with dependent children (AFDC) and supplemental security income (SSI). In most States, one's eligibility for two or more of the programs is determined within the same agency or department. Yet, administrators still fail to inform the recipients of their eligibility for benefits under other programs. The study found this to be the case in social security district offices which have the potential of informing the individual of his or her eligibility for SSI, medicaid, food stamps, title XX social services, and other programs offered by the States to SSI recipients.

12. The Comprehensive Employment and Training Act training and public service employment programs and the vocational rehabilitation program restrict participation of older persons because these programs rely for their success on the public and private employment markets, which often discriminate in employment on the basis of age, and which often maintain compulsory retirement policies.

Example: The executive director of the Urban League of Colorado testified:

> It is not widely announced, "You are too old to come to work for us," but the kind of response we get to candidates that we are referring to various employers indicate to us that those employers have drawn specific kinds of lines based on the age of workers that they are looking for . . .[10]

Example: Many of the vocational rehabilitation administrators interviewed by the Commission staff conveyed that their placements are tied to the fact that employers discriminate on basis of age. Therefore, because of the extent to which the VR standards focus on competitive jobs and the program relies on a discriminatory job market, the program will continue to focus on those the labor market will accept.

13. Efforts to end discrimination on the basis of age in Federally supported programs and activities must also address themselves to discrimination in the job market if the problem of age discrimination is ultimately to be solved.

The Commission contends that the effective implementation of the Age Discrimination in Employment Act must "move in concert" with a more vigorous enforcement effort under the Age Discrimination in Employment Act of 1967.

14. Discrimination on the basis of age occurs when program administrators provide services to some age groups rather than others because of a belief that providing services to them will provide a better return on the government's investment.

Example: The regional community mental health center administrator for Florida told the Commission:

> I think that one of the biggest areas of discrimination in terms of age has to do with health economics—just the whole economic structure behind it and how health services are paid for . . . when community mental health centers, administrators and boards sit down to discuss health policies, everybody is more interested in how it is going to be paid for and whether they are going to get the money to pay for the services, rather than the actual need for the services. You cannot deny . . . that the elderly services would not constitute a higher risk group, yet trying to convince policymakers that the present health economic structures would help pay for this service is difficult.[11]

Example: Administrators of the CETA programs also view "cost" in terms of what the investment of resources is when the length of time over which an individual would benefit is considered.

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[10] Page 62 of report cited in footnote 4.
[11] Page 69 of report cited in footnote 4.

15. Age categorical programs, such as those authorized under the Older Americans Act, are used to justify limiting the participation of older persons in other services programs.

Example: The Department of Labor administers both the CETA jobs program and title IX (Community Service Employment for Older Workers.) of the Older Americans Act. The Commission staff found that local sponsors often fill CETA slots with persons under 55 years of age because "they have the title IX program."

Example: The President of the Legal Services Corporation program pointed out how the existence of title III (of the Older Americans Act) funds for legal services for the elderly has prompted local legal services attorneys from ranking older persons high in their priorities. They have "another source" to tap whereas many of their other potential clients have no such alternative.

16. Negative staff attitudes toward older persons predispose program administrators to neglect or avoid serving older persons.

Example: A psychiatrist with a community mental center in San Francisco explained that the reason for lack of health services to older persons was that "psychiatrists, psychologists, social workers, nurses and other mental health personnel are not as interested in treating the aged as they are in younger patients." [12]

17. Age discrimination is fostered by the fact that many staffs involved in health, and social services lack the kind of pre-service or in-service training that would equip them for dealing with the needs of older persons.

Example: Sparse geriatric training in medical and nursing schools has resulted in a shortage of trained personnel within the country's health centers. Many of the health facilities visited by the Commission staff expressed the need for in-service training as present staff are inexperienced and thus the reason for underservice to children and older persons.

Example: The first U.S. Commissioner on Aging, now chairman of the task force on aging of the American Public Welfare Association, told the Commission that most social workers, attorneys, and medical professionals have failed to incorporate into their curricula any deep concern or interest about the needs of older people and the impact of aging on our society.

18. Admission to some medical schools is denied on the basis of age.

Example: 28 of 114 medical schools interviewed list age restrictions in their selection criteria. One school went as far as to state in its information bulletin "applicants over the age of 30 will rarely be considered. No applications from persons over 35 will be accepted." [13]

19. Institutions of higher education are increasingly providing new opportunities to meet the needs of the so-called nontraditional student, those over the age of 22.

Example: Universities throughout the country are waiving national standardized tests for older persons, reducing or eliminating tuition costs, developing special continuing education programs to meet the needs of their community older persons, an emphasis on retraining

[12] Page 72 of report cited in footnote 4.

[13] See the end of this chapter for a minority view expressed by Stephen Horn, Vice Chairman of the U.S. Commission on Civil Rights.

courses as well as short-term training courses, options to take courses on a credit or noncredit basis, options for attending classes off-campus, etc.

III. COMMISSION RECOMMENDATIONS

(1) That age should be used as a criterion for eligibility in federally assisted services and benefit programs only when Federal legislation contains a specific authorization for doing so.

(2) That any person aggrieved by violations of the act should have the right to institute a civil suit in a court of competent jurisdiction.

(3) That an Executive Order be issued granting to the Department of Health, Education, and Welfare authority to approve regulations developed by other Federal departments and agencies to implement the Age Discrimination Act.

(4) That an administrative sanction be available to Federal departments and agencies when dealing with violations of the Age Discrimination Act of 1975 that may be applied without terminating or interrupting services to eligible persons.

(5) That the units within the Federal departments or agencies responsible for administering federally assisted services and benefit programs be required by regulation to take the following steps to open up opportunities to participate in such programs to persons of all ages:

(a) That the operating units of the Federal departments or agencies require their grantees or contractors to set performance goals and plans of action for the participation of persons in their programs, based on the relationship of the age groups within the eligible population to the total population eligible for the programs, within the boundaries of the service area.

(b) That the operating units of the Federal departments and agencies require their grantees and contractors receiving Federal funds for the delivery of services and benefits to collect data on the age of applicants for, and beneficiaries of, each service and benefit provided by the program or activity.

(c) That the operating units conduct a semiannual self-assessment of the progress of their grantees and contractors in achieving the goals and implementing the action plans established for the delivery of services and benefits to eligible persons.

(d) That the Department of Health, Education, and Welfare conduct, on a sample basis by program, a continuing audit of the self-assessment effort; and

(e) That where audits reveal a failure to set goals for the participation of all age groups, or a failure to engage in "good faith" efforts to achieve the goals set and unwillingness to enter into voluntary compliance agreement, steps should be taken by the operating units of the Federal departments and agencies to apply the sanctions authorized by the act.

(6) That Federal departments and agencies administering federally assisted programs uniformly define in regulations "age" and "age-related terms."

(7) That Federal departments and agencies take the following administrative actions to facilitate implementation of the act:

(a) That subject to the authorities vested in the Secretary of Health, Education, and Welfare, and in the heads of other

Federal departments and agencies, primary responsibility for the day-to-day enforcement of the act be placed with the units within the Federal departments and agencies that have been given responsibility for the implementation of the program subject to the act.

(b) That all Federal departments and agencies responsible for programs subject to the act, review all of the relevant authorizing statutes, implementing regulations, and administrative policies to determine whether any restrictions based on age exist in their regulations or policies which do not have an express foundation in the pertinent statute.

(c) That each Federal department and agency take steps to ensure that each of its program is carrying forward an outreach program; and

(d) That Federal departments and agencies administering programs which require needs assessments and the preparation and publication of plans or applications also require publication of the needs assessment with an analysis by age.

(8) That the Congress require the Department of Health, Education, and Welfare to file an annual report with the Congress on the progress and steps taken to implement the Age Discrimination Act; and that other Federal agencies be required by Executive Order to submit to the Department of Health, Education, and Welfare an annual report which the Department will evaluate and submit as a part of its annual report.

(9) That the Department of Health, Education, and Welfare review all of its training assistance programs to institutions or to individuals and ascertain whether its funding policies are resulting in making available sufficient personnel to meet the needs of particular age groups.

(10) That more vigorous enforcement of the Age Discrimination in Employment Act of 1967 be pursued.

(11) That as a significant step to participation in CETA and VR programs, the Congress enact the House of Representatives version of H.R. 5383. This bill, if it becomes law, would raise the ceiling in the Age Discrimination in Employment Act from 65 to 70 and would end compulsory retirement in most agencies of the Federal Government.[14]

(12) The Commission makes the following recommendations in the field of education:

(a) That age should not be included in the criteria which are used to determine eligibility for admission to medical and other professional schools that are supported in whole or part by the Federal Government.

(b) That the following actions be taken in the field of vocational education: (1) That the Office of Education, based on data provided through State and local needs assessments, develop appropriate technical assistance strategies designed to assist State vocational education agencies to effectively work with its grantees to develop vocational education programs and activities to attract and to meet the needs of older persons; and (2) that a failure on the part of the State vocational education agencies

[14] H.R. 5383 was signed into law on April 6, 1978 (Public Law 95–256).

to respond to this initiative on the part of the Office of Education be regarded as a violation of the Age Discrimination Act of 1975 and that appropriate steps be taken to apply the sanctions recommended in this report.

(c) That the following actions be taken with respect to adult basic education: (1) That the Office of Education develop outreach mechanism to help State education departments to find and serve eligible individuals under the adult basic education program, including the approximately 15 million persons who are 55 or older; and (2) that a failure on the part of the State education department to respond to this initiative on the part of the Office of Education be regarded as a violation of the Age Discrimination Act of 1975 and that appropriate steps be taken to apply the sanctions recommended in this report.

(d) That institutions of higher education continue to develop and expand educational programs that take into account the interests and needs of persons of all ages.

IV. FUTURE ACTION

As indicated, the Age Discrimination Act of 1975 will not be fully implemented until January 1979. The first step of the congressionally mandated timetable—part 1 of the Commission's report—has been completed. Now it is up to the Congress to consider the recommendations of the Commission for amending the law before regulations are promulgated.

On January 20, the House of Representatives' Subcommittee on Select Education began Congressional consideration at a hearing on the Commission's recommendations for amending the Age Discrimination Act. Dr. Arthur S. Flemming, Chairman of the U.S. Commission on Civil Rights, supported the findings and recommendations of the Commission.[15] He also summarized the Commission's chief recommendations:

> The introduction by administrators of age as a cirterion for denying access to services and benefits should be prohibited by law.
>
> Administrators of services and benefit programs financed in whole or part by Federal funds should be required to institute plans of action for the participation of persons in their programs based on the relationship of the age groups within the eligible population to the total population eligible for the programs within the boundaries of the appropriate service area.[16]

These recommendations and others will be considered by the House Education and Labor Committee and the Senate Human Resources Committee.[17] The Commission would like the act to be

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[15] See parts II and III of this chapter for the detailed findings and recommendations of the U.S. Commission on Civil Rights.

[16] Testimony by Dr. Arthur S. Flemming, Chairman, U.S. Commission on Civil Rights, before the Subcommittee on Select Education of the Education and Labor Committee, U.S. House of Representatives, Jan. 20, 1978.

[17] Congressman Claude Pepper, Chairman of the House Select Committee on Aging, issued a press release on Jan. 10, 1978, indicating that he proposed to introduce legislation based on the recommendations of the U.S. Commission on Civil Rights and adding "age to every piece of Civil Rights legislation which currently protects citizens from discrimination because of race, color, sex, religion and national origin."

amended before the regulations are proposed. In the Commission's letter of transmittal accompanying the report, Dr. Flemming indicated:

> If our recommendations are accepted, we believe that the act will require the issuance of a comparatively small number of regulations.

Part II of the Commission's Study, which will further document the Commission's findings in individual programs, will be released by the end of February. The proposed regulations interpreting the act as now worded, are being drafted within the Department of Health, Education, and Welfare. These proposed regulations will then be subject to comment period by the public and Congress for possible revision. Then, in accordance with section 304(a)(3), the final Government-wide regulations must be published no later than 90 days after the date of publication of the proposed regulations. Following the issuance of the final Government-wide regulations (not later than 90 days according to the law), all Federal departments and agencies administering federally assisted programs and activities must publish proposed regulations in accordance with the guidelines in the Government-wide regulations. The effective date of these final regulations must be no later than January 1, 1979. Therefore, the full enactment of the Age Discrimination Act will be no earlier than 1979.

During the period between the issuance of the report—January of 1978—and the implementation of the act—January 1979—the Age Discrimination Act will be under intensive analysis by Federal, State and local agencies, the general public, academia, and the Congress. The practicality of eliminating age as a determinant in admission for medical schools has already been challenged by the Commission's Vice-Chairman, Stephen Horn. Dr. Horn, president of California State University, expressed his views in the Commission's report.

> In selecting students for admission to medical school, all applicants must compete on an equal basis for limited and finite number of positions, regardless of age. Data supplied to the Commission by the Association of American Medical Colleges demonstrate that older applicants are admitted in lesser proportions than younger; but data also show that, on the average, older applicants present less competitive academic credentials the further removed from their college years. It is reasonable and necessary that medical schools choose students who are believed most likely to be able to complete their education and devote their lives to providing needed medical services.
>
> In 1976, there were 42,155 applicants for 15,774 positions (2.7 applicants for each position). 37,559 were under 27 years of age and 4,546 ranged from 28 to 53 years of age. 1,011 of the older group were accepted. On the average, they had academic credentials which were lower but approximated those of the younger population who were admitted. The 3,535 who were not accepted had significantly lower academic credentials, for the most part lower than those not accepted from the younger group. It appears that the medical schools

are not excluding applicants solely because of age. Rather, they selectively admit applicants from across the entire age spectrum who are deemed sufficiently qualified to justify having the limited and finite resources available expended upon their education.

Access to a medical education is not provided by our society for the purpose of personal gratification or fulfillment. Those who are accorded the privilege to enter medical school must be academically and personally prepared to succeed and to fulfill the Nation's need for physicians and their service. Although age should not be a reason for exclusion, age must not make a reason for demanding inclusion.[18]

These and others views, will bear close analysis as implementation of the act becomes reality in what Dr. Flemming refers to as "a vigorous and unequivocal implementation of the Age Discrimination Act." [19]

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[18] Pp. 106–108 of report cited in footnote 4.
[19] Testimony presented by Dr. Arthur Flemming, Chairman, U.S. Commission on Civil Rights, before House Subcommittee on Select Education, Jan. 20, 1978.

CHAPTER X

AREAS OF CONTINUING CONCERN

I. MINORITIES

Committee on Aging reports have emphasized that elderly members of minority groups often are exposed to a form of "multiple jeopardy" because of their age, race, or language barriers.[1] This has frequently caused them to experience greater hardship and deprivation than other older Americans.

In recent years, though, the economic well-being of aged minority members has improved because of social security increases, the advent of supplemental security income, and benefit boosts in other income maintenance programs. Nonetheless, they still lag far behind other older Americans by almost any standard of measurement.

The year 1977 brought little change in this overall situation. The results of the 1977 Bureau of the Census income survey are mixed. Proportionately fewer minority members lived in poverty in 1976 than in 1975.[2] However, the number of impoverished minority aged remained almost unchanged. And their incidence of poverty continues at a disturbingly—and sometimes shockingly—high rate.

More than one out of every three (34.8 percent) aged blacks is poor, as defined by the Bureau of the Census. In sharp contrast, about one out of every eight (13.2 percent) elderly whites lives in poverty. Nearly one-half (49 percent) of all aged blacks is either poor or near poor, compared with about one-fifth (22 percent) for elderly whites. Negro women 65 years or older continue to be among the most economically disadvantaged members of our society today. Almost three out of every five would be classified as poor or marginally poor.

The Spanish-origin elderly encounter similar economic problems. They are more than twice likely to be poor as aged Anglos, and quite frequently they suffer greater extremes of deprivation.

TABLE A.—PERSONS AGED 65 OR OLDER LIVING IN POVERTY[1] OR NEAR POVERTY[2] BY RACE

[In thousands]

	Total noninstitutionalized population		Persons living in poverty		Percent poor		Persons living in poverty or near poverty		Percent poor and near poor	
	1975	1976	1975	1976	1975	1976	1975	1976	1975	1976
Whites	19,654	20,020	2,634	2,633	13.4	13.2	4,516	4,560	23.0	22.3
Blacks	1,795	1,852	652	644	36.3	34.8	926	908	51.6	49.0
Spanish origin	420	464	137	128	32.6	27.6	(3)	177	(3)	38.1

[1] Annual income, on a weighted basis: Aged individual, 1975, $2,572; 1976, $2,720; 2-person family with an aged head, 1975, $3,232; 1976, $3,417.
[2] Annual income, on a weighted basis: Aged individuals, 1975, $3,215; 1976, $3,400; 2-person family with an aged head, 1975, $4,040; 1976, $4,271.
[3] Information not available.

Source: Bureau of the Census.

[1] See, for example, "Developments in Aging: 1973 and January–March 1974", p. 139, and "Developments in Aging: 1976," p. 132.
[2] The 1977 Bureau of the Census income survey, based upon a questionnaire sent out to respondents in March 1977, provides information about the income of Americans in 1976.

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New programs in recent years have helped to make services and service opportunities more readily available for all older Americans, including members of minority groups. A number of these programs give special attention to needs of minority groups.

The title IX senior community service employment program [3] provides job opportunities for low-income older Americans in a wide range of useful and fulfilling activities. As of June 30, 1977, approximately one-fourth to one-third of all title IX workers were members of minority groups: 74 percent were white, 20 percent were black, 3 percent were native Americans, and 3 percent were members of other races. Spanish Americans accounted for 6 percent of title IX participants, and were included among these racial groups. These figures closely parallel the racial participation rate in 1976.

One of the major target groups of the Older Americans Act—particularly for the title III State and community programs on aging and the title VII nutrition program for the elderly—is the minority aged.[4] About one out of every five participants in the national hot meals program in the third quarter of 1977 was a member of a minority group. A similar ratio existed for recipients of title III services.

MINORITY AGED PARTICIPATION IN TITLE III (STATE AND COMMUNITY PROGRAMS ON AGING) AND TITLE VII (NUTRITION PROGRAM FOR THE ELDERLY) OF THE OLDER AMERICANS ACT

[3rd quarter, fiscal 1977]

	Title III (percent)	Title VI (percent
Native Americans	0.7	1.0
Black	13.0	11.0
Oriental	.8	.8
Spanish language	5.0	5.0
Other	2.0	2.0

Source: Administration on Aging.

ACTION's older Americans volunteer programs—retired senior volunteer program (RSVP), foster grandparents, and senior companions [5]—provide service opportunities for persons 60 or older. Foster grandparents and senior companions receive small stipends for performing services, but RSVP participants are reimbursed only for their out-of-pocket expenses. For fiscal year 1977, ACTION estimates that minority members constituted 13.5 percent of RSVP participants, 28 percent of foster grandparents, and 44 percent of senior companions.

[3] For additional discussion of the senior community service employment program, see chapter VIII.
[4] For additional discussion of the State and community programs on aging and the nutrition program for the elderly, see p. 117.
[5] For additional discussion of ACTION's older American volunteer programs, see p. 215.

ESTIMATED NUMBERS AND PERCENTAGE OF ELDERLY PERSONS, BY RACE, PARTICIPATING IN ACTION'S OLDER AMERICAN VOLUNTEER PROGRAMS FOR FISCAL 1977

Race	RSVP		Foster grandparents		Senior companions	
	Number	Percent	Number	Percent	Number	Percent
Whites	203,275	86.5	11,304	72.0	1,400	56.0
Blacks	21,620	9.2	2,826	18.0	775	31.0
Hispanics	4,700	2.0	785	5.0	288	11.5
Native Americans	1,175	.5	753	4.8	25	1.0
Other	4,230	1.8	32	.2	12	.5
Total	235,000	100.0	15,700	100.0	2,500	100.0

Source: ACTION.

The supplemental security income program,[6] which became effective in 1974, assures all aged, blind, and disabled persons a minimum monthly income of at least $177.80 for qualifying individuals ($266.70 a month for eligible couples). About 3 out of every 10 SSI recipients reporting their race are members of minority groups.

The number of SSI recipients, by category, in June 1977 totaled 4,223,742: aged, 2,095,921; blind, 76,255; and disabled, 2,051,566.

PERCENTAGE DISTRIBUTION OF SSI RECIPIENTS BY RACE IN JUNE 1977

	Total	Aged	Blind	Disabled
White	64.4	65.2	61.7	63.6
Black	26.8	24.4	29.7	29.1
Other	2.8	2.9	2.8	2.7
Not reported	6.1	7.5	5.9	4.7

[1] The percentages are rounded to the nearest 10th of a percent, and therefore do not total 100 percent.
[2] The figures include recipients of federally administered State supplementary payments.

Source: Social Security Administration.

A. Key Developments Affecting the National Center on Black Aged

The National Center on Black Aged was established in 1973 under an Administration on Aging model project grant. The center serves as the staff arm for the National Caucus on the Black Aged, which is a membership organization responsible for developing policy proposals concerning the needs of elderly blacks. Membership in the National Caucus of the Black Aged increased more than threefold during the past year—from 300 to 1,250.

[6] For additional discussion of the supplemental security income program, see chapter I.

In 1977, the center built upon its earlier activities as well as developed new initiatives. The center took the lead in 1976 in advocating the development of research concerning the minority aged by sponsoring a full day's symposium at the annual meeting of the Gerontological Society. At the 1977 Gerontological Society meeting in San Francisco, the center sponsored another discussion session regarding the minority aged.

On other fronts, NCBA assisted the Administration on Aging in developing its minority research program. In addition, the center provided training sessions for researchers and instructors in the field of aging.

The annual conference, held in May 1977 in Washington, D.C., focused on health and the black elderly. Members of the Congressional Black Caucus attended the meeting and conducted a hearing on major health issues affecting aged and aging blacks. A research symposium was also held during the annual conference, concentrating on major deficiencies in gathering data relative to the black aged. In addition, several workshops were conducted on long-term care, delivery of services, and other issues.

One of the major needs of aged and aging blacks is improved housing at prices within their reach. Many now live in dilapidated, deteriorating, or otherwise substandard housing. NCBA established a housing board in 1977 to develop housing projects for the minority aged. A 175-unit project for Washington, D.C., has been approved by the Department of Housing and Urban Development. An application for a 150-unit high rise apartment in Houston, Tex., has been submitted. NCBA plans to submit proposals for other projects.

Among the major federally funded activities and proposals sponsored by NCBA:

Current programs and grants of the National Center on Black Aged

Program	*Grant/contract amount*
The National Center on Black Aged core budget	$300,000
Manpower:	
"Technical Assistance and Training for Developing Manpower Programs to Serve The Minority Elderly"	130,000
Transportation—NCBA elderly escort services project, Springfield Mass.:	
(1) Title X	130,000
(2) Comprehensive and Employment Training Act (CETA) (Hampden County, Mass.)	76,750
CETA—"CETA Workers in the Field of Gerontology"	160,000
Technical assistance and training for developing manpower programs	130,000
Training and Education:	
Technical assistance and training for the D.C. Office on Aging	15,000
Development and quality improvement of gerontology training	103,000
Quality improvement for minorities: students, faculty, and institutions (1977–1979)	215,000
A design for gerontology, curriculum development in minority aging, Mississippi State Valley University	3,800
D.C. Providers Council	23,000
Training for outreach workers (Delaware Office on Aging)	1,900
Research:	
"A Scientific Research Symposium on Health and Black Aged"	7,710
Model antivictimization project	113,000
Informal social networks in support of elderly blacks in the black belt of the United States (1977–1979)	240,000
Total grants and contracts	1,649,160

Housing (section 202 projects):
Washington, D.C., 175 units (HUD mortgage approval pending), mortgage amount, $6.9 million.
Houston, Tex., 150 units (reservation received, no approvals thus far), mortgage amount, $3.5 million (estimate).

B. National Indian Council on Aging Completes First Project Year

In September 1977, the National Indian Council on Aging completed the first year of operations under its 3-year AoA model project grant.[7] The Council took numerous actions throughout 1977 to document and discuss the needs of elderly Indians. Among these actions:

—Participation in national meetings focusing on the needs of the elderly,
—The hiring of a liaison specialist, based in Washington, D.C., charged with bettering communications between the Council, the Congress, and the executive agencies,
—Providing input to State and Federal service providers, and
—Fulfilling its mission as the chief representative of older Indians before Congress.

In this last role, Council representatives testified at Committee on Aging hearings on needs of the rural elderly in March 1977 at the annual meeting of the Western Gerontological Society in Denver—and in Arizona and New Mexico in the Fall of 1977.[8] Testimony was also presented in February 1978 before the Senate Subcommittee on Aging as it considered the reauthorization and amendment of the Older Americans Act. Council witnesses stressed that Indian elderly could be best helped by Federal programs which recognized tribal sovereignty, and which permitted the tribes the option of direct funding from the Federal Government. In support of this position, the Council made available statistics indicating that, under current funding formulas, older Indians were not receiving services equivalent to those being provided to other groups.

Council recommendations are receiving consideration during congressional review of the Older Americans Act. In addition, during 1978 and 1979, the overall relationship of the Federal Government to native Americans must be reviewed by the Congress in response to the final report of the American Indian Policy Review Commission.[9] The Commission, after 2 years of study, concluded that Indians are "the most disadvantaged minority group in the Nation" and recommended that all Federal assistance funds be distributed directly to tribal governments.

Native American leaders will again meet at the Second National Indian Conference on Aging. It is scheduled to be held in Billings, Mont., in August 1978 and to focus specifically on health-related issues.

AOA acts to assure title III equivalency

In May 1977, the Administration on Aging issued program instructions designed to assure that elderly Indians receive equivalent

[7] For background on the Council's founding, see "Developments in Aging: 1976", p. 138.
[8] For further details on these hearings, see chapter VI of this report.
[9] "American Indian Policy Review Committee: Final Report", May 17, 1977, GPO No. 052-070-04165-0.

benefits under the provisions of title III (State and community programs) of the Older Americans Act.[10] This new AOA policy:

—Requires each State having an Indian tribe within its borders to submit an action plan for serving elderly Indians as part of its State plan for each fiscal year.

—Requires that the State plan also contain assurances that elderly Indians will receive benefits equivalent to those received by all non-Indian individuals within the same plan area; and that representatives of each tribe within the State be permitted to review and comment upon area agency on aging and State plans.

—Encourages the selection of Indian agencies and organizations to provide services to elderly Indians.

—Permits the Commissioner on Aging to make the final review of the State plan and, if he is not satisfied that it will result in equivalent benefits, to directly fund any Indian tribe within the State.

C. Activities of the Asociacion Nacional Pro Personas Mayores

The Asociacion Nacional Pro Personas Mayores was established in 1975, with the assistance of an Administration of Aging (AoA) model project grant, in order to bring about a greater involvement of the Hispanic elderly in State and Federal aging programs, and to assist researchers and lawmakers to better understand the needs of this group. The asociacion has proceeded toward these goals through congressional testimony, national conferences, and ongoing research projects.

Carmela G. Lacayo, national executive director, testified in behalf of the needs of the Hispanic elderly at congressional hearings examining the Older Americans Act. In October 1977, speaking for the asociacion as well as for the National Center on Black Aging and the National Indian Council on Aging, she told a House subcommittee that minority elderly had not been able to participate in title IX community service employment programs to an adequate extent. Ms. Lacayo continued:

> The Asociacion Nacional, the Black Center on Aging, and the National Indian Council on Aging all agree that tighter administrative regulations and tighter affirmative action enforcement will not adequately safeguard their [minority elderly] access to participation in the programs under title IX. Such promises have been made in the past and have not institutionalized equal participation by minorities in government programs on aging.
>
> In order to ensure equitable participation in title IX moneys, the minority elderly must be allowed to contract with the Department of Labor on an equal basis with the five national aging organizations that directly contract with DOL.[11]

And, in early 1978, Ms. Lacayo addressed the Senate Subcommittee on Aging as it began its hearings for the reauthorization of the Older Americans Act. After declaring that "my community has essentially

[10] AOA-PI-77-21; May 26, 1977.
[11] Testimony before the House Subcommittee on Income and Employment, Oct. 5, 1977.

been ignored by the Federal aging network and has not been included in the activities and services provided under the act," [11a] she outlined the asociacion's proposals for the redressing of this situation. They included:

—Fixing responsibility, and accountability, for assuring affirmative action within the area agencies on aging.

—Strengthening the affirmative action mandate within the Older Americans Act; and

—Requesting that the U.S. Commission on Civil Rights be directed to investigate discrimination in programs for older Americans.[11b]

The Asociacion's other major projects for the year included The Second National Hispanic Conference on Aging, held in Washington, D.C., in October 1977. This bilingual symposium brought together social scientists, legislators and other government officials, and the Hispanic elderly, for 3 days of information-sharing. The asociacion has also begun, with the assistance of an AoA grant, a national research project for the purpose of evaluating the needs of the Hispanic elderly; emphasis will be placed on differentiating between the conditions of the major subgroups, including Mexican- and Cuban-Americans, as well as Puerto Ricans.

Better statistical data about the Hispanic elderly should also become available as Federal agencies move to comply with Public Law 94-311, which mandated the improvement of social statistics for Hispanic Americans. For example, the Department of Commerce has expanded its data-gathering activities to provide reliable employment data on the Hispanic population by age and sex.[11c]

D. New Data From the Pacific Asian Elderly Research Project

The Pacific Asian Elderly Research Project (PAERP), established in 1976 with the assistance of an AOA grant, is dedicated to development of health and social services which can be effectively delivered to, and utilized by, elderly persons of Oriental and Pacific ethnic background.[11d]

During 1977, PAERP issued a compilation and analysis of existing statistical information which, while yielding significant new information, also demonstrated the inadequacy of existing data as compiled by various Federal agencies.[12] Existing gaps are particularly severe for three areas of prime concern to the elderly: housing conditions, health status, and social security benefits. In order to correct these deficiencies, PAERP recommends that, in subsequent censuses and other data-collecting activities:

—Data should be made available for all the Pacific Island and Asian American groups.

—Data should be reported not only on a national basis but for States, standard metropolitan statistical areas, and cities.

—Data should be divided into cohorts of 5 years for all Pacific-Asian elderly between the ages of 55 and 75.

[11a] Testimony before the Senate Subcommittee on Aging, Feb. 3, 1978.

[11b] The National Urban League has prepared, under an AoA grant, an affirmative action manual for Federal aging programs, "Civil Rights Responsibilities in Aging Programs," November 1976.

[11c] Congressional Record, Jan. 25, 1978, p. E140.

[11d] Additional information concerning the establishment and initial operations of PAERP may be found in "Developments in Aging: 1976," p. 142.

[12] "Understanding the Pacific Asian Elderly—Census and Baseline Data: A Detailed Report," prepared by the Pacific Asian Elderly Research Project under AOA Grant No. 90-A-980/1; August 1977.

—Data (e.g., housing and social security statistics) should be reported for the Pacific Asian elderly group in the same manner as it is for other elderly ethnic and racial groups.

Despite the limitations of existing statistical information, PAERP's study revealed significant differences between the Pacific Asian elderly and the general aged population including:

—A far higher rate of growth;

—A higher proportion of males who also live alone and continue to participate in the labor force;

—A higher proportion of elderly who were foreign born, live in cities, and are less well educated;

—Lower median incomes and social security payments.

During 1978, PAERP plans to submit to the Administration on Aging a proposal for the establishment of a national advocacy organization for the Pacific and Asian Elderly.[13] [14]

FINDINGS AND RECOMMENDATIONS

The year 1977 brought little improvement in the economic well-being of elderly minority members. The 5.9 percent cost-of-living increase in social security and supplemental security income provided some protection from rising prices. The extension of cost-of-living protection to special minimum social security beneficiaries under the 1977 Social Security Financing Amendments will help aged minority members, as will the 27.8 percent increase in benefits for qualifying persons (by increasing the multiple for computing the benefit from $9 to $11).[15]

Major and comprehensive actions * are needed to improve the quality of life for minority senior citizens. Some efforts may require long-range planning because of cost considerations and the need for additional data to develop sound and effective policies. However, several immediate actions can be taken to improve Federal programs for the minority aged or make Federal benefits more accessible to them, including:

—The Department of Labor should take steps to assure that the elderly minority group members serve in, and are served by, title IX of the Older American Community Service Employment Act.

—the Department of Housing and Urban Development should promote more minority sponsorship of housing for older Americans.

—Federal agencies administering programs with an emphasis on responding to the needs of low-income persons should make a special effort to encourage greater minority participation.

—the Administration on Aging should encourage minority persons to pursue careers in gerontology.

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[13] Conversation with Sharon Fujii, Ph. D., principal investigator, PAERP; Oct. 10, 1977.

[14] During August of 1977, Committee on Aging staff investigated the eviction of elderly Chinese and Filipino tenants from the International Hotel in San Francisco. Further details are contained in Chapter VII of this report.

[15] See chapter I for additional discussion of changes in the special minimum monthly benefit provision.

*See chapter VIII for recommendation asking direct Older Americans Act funding for Indian tribal organizations.

II. THE NATIONAL INSTITUTE ON AGING: GROWING INFLUENCE

Despite very low budgets—$30 million for fiscal year 1977 and $37.7 million for fiscal year 1978—and a relatively small staff, the National Institute on Aging (NIA) was able to take marked steps during 1977 in expanding the knowledge base about the aging process and coordinating this knowledge with other research efforts. The Institute coordinated and sponsored numerous workshops and meetings with other institutes and agencies, including:

—A joint workshop of the National Institute of Neurological and Communicative Disorders and Stroke, the National Institute of Mental Health and NIA on "Alzheimer's disease—senile dementia and related disorders";

—A "workshop on aging" with the National Aeronautics and Space Administration (NASA) and the NIA on the use of prosthetics and how to transfer techniques used by the space program to use by the elderly;

—A conference on geriatic medicine sponsored by the NIA and attended by deans of medical schools and professors of medicine from throughout the country;

—A joint workshop with the President's Council on Physical Fitness and Sports and the NIA on "exercise in the elderly";

—A joint meeting with the World Health Organization, the Fogarty International Center for Advanced Sciences and the NIA with directors of national institutes with programs in the field of aging;[16]

—Work with the National Cancer Institute and the President's Special Assistant for Health Issues on the potential use of certain drugs now prohibited in this country for treatment of cancer patients and other terminal diseases;

—A press conference pointing out the relationship of harsh winter weather and accidential hypothermia for the elderly;

—A joint workshop of the National Institute of General Medical Services and the NIA on "pharmacology and aging"; and

—A conference sponsored by the NIA on "protection of human subjects" to explore ethical issues relating to elderly subjects in human studies.

The National Institute on Aging was established by the Research on Aging Act of 1974 (Public Law 93–296) to conduct biomedical, social, and behavioral research related to the aging process. The NIA research efforts are conducted by intramural and extramural programs.

The intramural program is conducted at the Baltimore Gerontology Research Center in Maryland. The center is divided into four branches: behavioral sciences, clinical physiology, cellular and comparative physiology, and molecular aging. In addition to numerous research efforts with animal models, the GRC has a longitudinal study of males, "Baltimore longitudinal study," which will celebrate its 20th anniversary next year. Women are to be included in the longitudinal study this year.

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[16] See chapter XI, Worldwide Attention on Aging, for a description of the Senate Committee on Aging hearing on "Graying of Nations," held in conjunction with the NIA meeting.

Center plans also include studies on balance and studies on nutrition, expansion of the animal colonies, developing research in geriatric medicine, and broadening opportunities for behavioral medicine studies.

The NIA extramural program supported 209 research grants during fiscal year 1977, in addition to 48 training grants and 19 contracts. The Institute was able to fund 56 percent of its competing grants—128 out of 227—distributed as follows: biological sciences (56 percent), clinical sciences (8 percent), behavioral and social sciences (23 percent), and multicategorical areas (13 percent).

Awards made in the biological sciences included:

—Protein turnover and aging (University of South Alabama);
—Aging in connective tissue, brain and auditory system (Boston University);
—Role of membranes in the aging process (Medical College of Pennsylvania);
—Bioenergetics of aging (Albany Medical College);
—Role of chromosomal proteins in aging (University of North Carolina);
—Effects of aging on central temperature controls (University of Texas Health Science Center);
—Dietary factors in aging (University of Hawaii);
—Meal timing, circadian rhythms and lifespan (University of Minnesota);
—Effect of age and trauma on nutrient requirements (Rutgers University);
—Relationships of diet and air pollutants to aging (University of Minnesota);
—Cellular immune response and mechanisms of aging (University of Alabama);
—Water and ions in muscle and collagen in aging (University of Oklahoma);
—Biochemical changes in developing and aging muscles (Boston Biomedical Research Institute);
—Skeletal cell and matrical changes during aging (New York University);
—Biochemical regulation of the aging process (Temple University);
—Control of cell division: an approach to aging (Florida State University);
—Aging and immune responses to transplants and tumors (Children's Hospital of Philadelphia);
—Decline of immune response with aging (Jackson Laboratory of Maine);
—Functional age changes in female reproductive organs (University of Cincinnati);
—The drug sensitivity of aging cells (University of Rochester);
—Neuronal aging in the auditory and visual systems (Boston University);
—Control of production and secretion of insulin during aging (Temple University);
—Host cell reactivation and DNA repair in aging cells (Harvard University); and
—Molecular interactions in aged and arthritic cartilage (Case Western Reserve University).

Awards made in the clinical science include:
—Ovarian function in postmenopausal women (Worcester Foundation for Experimental Biology);
—Physiologic responses of the aged to anesthesia (University of Pennsylvania);
—Neurophysiological studies of brain aging (University of California at Irvine);
—Protein needs of elderly people (Massachusetts Institute of Technology);
—Brain function and oxidative metabolism during aging (Duke University);
—Aging and event-related brain potentials in man (University of California at San Diego); and
—Glucose intolerance and aging (Yale University).
Examples of awards made in the behavioral research areas include:
—Psychological support systems for the terminally ill (University of California at San Francisco);
—Aging and inhibition (University of Washington);
—Animal models of declining memory in the aged (Princeton University);
—Sensory and perceptual processes in the aged (University of Georgia);
—Interaction between human aging and memory (Georgia Institute of Technology);
—Mental performance and aging (Veterans Administration Outpatient Clinic of Boston);
—Cognitive behavior in maturity and old age (University of Southern California);
—Neuropsychological studies of attention and aging (Tufts University);
—Age differences in semantic memory (University of Southern California);
—Psychosocial treatments for extended care facilities (State University of New York at Stoney Brook);
—Sleep and other neurobiological changes with aging (University of Washington);
—Age, imagery, reward and practice in verbal learning (Veterans Administration Outpatient Clinic of Boston);
—Organic brain syndrome in elderly community residents (Philadelphia Geriatric Center);
—Health care, decisionmaking and coping in the elderly (Stanford University);
—Attentional and pathway processes in the aged (Veterans Administration outpatient clinic in Boston);
—Age and timing of nutrition intake and wheel activity (Baltimore City Hospitals);
—Short-term retention in the aged (Princeton University);
—Psychological aspects of aging and dying (University of California at San Francisco); and
—Retrospective reports of personal events by the elderly (University of Californai at San Francisco).
Awards made in the societal sciences include:
—Adult lives and patterns of aging in urban setting (University of Chicago);

—Simulation of life cycles (Duke University);
—Social well-being and health of the aged across time (University of California at Riverside);
—Old age in America, 1855–1970 (Newberry Library of Chicago);
—A cross-cultural study of the aged (California State College at Bakersfield);
—Identifying and easing the reading demands of the aged (State University of New York at Albany);
—Migration of aged in the United States (University of Kansas); and
—Aging and health policy: critical policy linkages (Brandeis University).

Examples of the awards made in the multicategorical areas:
—Estrogen usage by postmenopausal women—coronary risk (University of California at Irvine);
—Analysis of genetic effects on aging (Jackson Laboratory of Maine);
—Hormone dynamics and target organs in aging men and women (University of Texas Health Science Center);
—Behavioral and neural plasticity in the aged rat (University of California at Irvine);
—Cellular and modecular aspects of aging (Philadelphia Geriatric Center); and
—Physiology of exercise and stress (University of California at Santa Barbara).

Areas scheduled to receive emphasis in the coming years at NIA include: Pharmacology, nutrition, retirement, endocrinology, immunology, the neurosciences, prosthetics, animal and biological resources, epidemiology, clinical trials, research geriatric medicine, longitudinal studies, and cell biology. In addition, the Institute plans to work with the Clinical Center on the NIH campus in diagnosis, treatment, and care of older persons. The NIA also hopes to coordinate efforts at the Clinical Center, such as training of medical students, with those of the Baltimore Gerontology Research Center.

Plans are in the making by the NIA and Fogarty International Center to bring outstanding geriatricians from Europe to spend time at NIA and the Fogarty Center and share their knowledge and experiences.

The development of a NIA position on training is planned in conjunction with the National Academy of Sciences recommendation relating to predoctoral training in the social and behavioral sciences.

At the request of the NIH Director, the NIA and the National Institute of Child Health and Human Development (NICHD) have begun consideration of a program on clinical nutrition.

III. STATUS OF BLOCK GRANT PROGRAMS

Other sources of funding are available for services for older Americans besides those programs specifically authorized under the Older Americans Act.[17] Among the most direct are social services grants to States under title XX of the Social Security Act, general revenue sharing, and community development block grants to States.

The nature of these programs—in which block grants of money are made to States or local governments which then determine how the

[17] See chapter VIII for discussion of social services under the Older Americans Act of 1965, as amended.

funds are to be spent—make it difficult to determine expenditures for services directed to older Americans.

The Committee on Aging does monitor available data, however, to detect trends affecting older Americans.

A. General Revenue Sharing

Legislative changes in the general revenue sharing program during 1976, while making some changes viewed as favorable to the elderly, may also make it harder to monitor expenditures.[18]

Information is not yet available on the effect of favorable changes. These changes included a repeal of the prohibition against using general revenue sharing funds as local matching money for other Federal programs, strengthened prohibitions against age discrimination in the use of funds, and a mandate to local governments to include older Americans in budget hearings and other fund allocation processes.

The Office of Revenue Sharing issued final regulations governing public participation and public hearings in September 1977 (effective October 1, 1977).[19] Final rules governing age discrimination are expected in March 1978.[20]

The 1976 reauthorization also repealed priority spending categories, one of which was social services for the poor or aged. Reports consistently have shown between 2 percent and 3 percent of total general revenue sharing expenditures in this category. The most recent report of actual use again shows 2 percent of total general revenue sharing funds expended in this category.[21]

Perhaps a more useful guide to revenue sharing expense is the Administration on Aging estimate that $13 million of general revenue sharing funds were "pooled" by State agencies on aging in 47 States during fiscal year 1977.[22]

B. Community Development Block Grant Assistance

Congress created a community development block grant (CDBG) program in 1974 to develop viable urban communities "by providing decent housing and a suitable living environment and expanding economic opportunities principally for persons of low and moderate income."[23] Information which became available in 1977 revealed older Americans have had limited success in influencing the use of CDBG funds specifically targeted at their needs. The identified percentage of funding for facilities and services for the elderly remains constant.

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[18] Public Law 94-488, signed into law Oct. 10, 1976. See *Developments in Aging: 1976, Part 1*, a report of the Committee on Aging, U.S. Senate, Report No. 95-88, p. 81, for a discussion of changes in general revenue sharing law affecting older Americans.

[19] 31 CFR part 51, subpart B. Federal Register, Sept. 22, 1977, vol. 42, No. 184, pp. 47987-47992.

[20] 31 CFR part 51, subpart E. Interim rules were published in the Federal Register on Apr. 6, 1977, vol. 42, No. 66, pp. 18361-18375.

[21] During entitlement period 6, from July 1, 1975 to June 30, 1976, a total of $170.9 million was reported expended for social services for the poor or aged—2 percent of a total expenditure of $6.955 billion. "Reported Use of General Revenue Sharing Funds," actual use reports, entitlement period 6, Office of Revenue Sharing, Department of the Treasury. Expenditures in this category, however, cannot be taken as full accounts of money spent on services for the elderly, as the category includes services for all age groups. Other expenditures for the elderly would also be reported under different categories, such as public transportation, health, recreation, or housing.

[22] "National Summary of Program Operations Under the Older Americans Act, Fiscal Year 1977," Administration on Aging, Office of Human Development Services, Department of Health, Education, and Welfare.

[23] "1977/78 U.S. Government Manual," page 289.

Another major development was the enactment of the Housing and Community Development Act of 1977.[24] The new law increases authorized funding levels. It may have potentially far-reaching implications for older Americans, particularly those living in central cities.

1. NEW DATA ON ELDERLY BENEFITS

The CDBG disbursement process of direct allocations to communities makes it difficult to evaluate the program's full range of assistance for older Americans. However, newly available studies give some indication of the directly traceable benefits.

A Brookings Institution study for the Department of Housing and Urban Development (HUD) revealed that older Americans have been active and effective in obtaining CDBG funds for activities within their communities. Similarly, the U.S. Conference of Mayors confirms that many cities have utilized CDBG funds for senior centers, recreation activities, information and referral programs, and transportation services benefiting the elderly. During fiscal years 1976 and 1977, only about 2 percent of all CDBG money was expended on facilities or services for older persons:

Fiscal year	Actual CDBG outlay (billions)	Percentage of outlay for elderly [1]	
		Facilities (percent)	Services (percent)
1976	$1.579	1.3	0.7
1977	1.779	.9	1.0

[1] Information obtained from U.S. Conference of Mayors; Mar. 1, 1978.

These percentages, however, are not representative of all benefits which have accrued to older persons during these years because the CDBG program is not monitored to trace the demographic groups benefiting from all of its activities. In addition, no significant conclusions about trends can be drawn from this data because of the limited period of the survey.

2. SOCIAL SERVICES

Social Services are funded under the CDBG program only if they are not otherwise available and are determined to be necessary and appropriate. HUD regulations set a 20 percent limit on the amount of CDBG funds which can be utilized for human services. Another requirement is that the services be supportive of other community development activities, such as assistance to persons displaced by redevelopment.

3. THE 1977 REVISIONS

The Housing and Community Development Act of 1977 made important changes in the CDBG program and other activities [25] which can assist older Americans and their communities. HUD issued final regulations on March 1, 1978, to implement key provisions in

[24] Public Law 95-128, approved Oct. 12, 1977.
[25] Revisions which affect housing programs for the elderly are discusssed in chapter VII of this report.

the new law.[26] The 1977 act reemphasizes congressional concern that benefits be directed at low- and moderate-income persons. It marks a shift in emphasis, though, from massive urban development projects to smaller scale efforts which conserve older cities and their neighborhoods. Individuals residing within the most distressed portions of central cities may significantly be benefited, including older Americans living in decaying neighborhoods. Older residents of smaller cities may also see their communities receive increased and more comprehensive aid. And all elderly should benefit from (1) the strengthening of the role of citizen participation and neighborhood organizations in determining community alterations, (2) increased funding for home rehabilitation, and (3) the strengthening of provisions for in-neighborhood relocation for persons displaced by revitalization activities.

Among the provisions in the new law which are potentially important for older Americans, are:

—A strengthening of the language to assure citizen participation by requiring block grant applicants to satisfactorily demonstrate that low- and moderate-income citizens have an opportunity to submit their views and to make them known at required local public hearings.

—Additional limitations on the use of CDBG funds for public services. The act now forbids any new use unless the UHD Secretary finds that events beyond the applicant's control require a waiver.

—Requiring applications to list all the resources which a community plans to allocate to neighborhood revitalization activities benefiting low- and moderate-income persons.

—Eligibility of grants to neighborhood-based nonprofit organizations for revitalization and community development activities.

—Direct funding for Indian tribes and Alaskan Native villages.

—The popular and successful section 312 rehabilitation program has been extended for 2 years. It provides direct Federal loans to bring properties up to all applicable code standards. President Carter's fiscal 1977 budget request of $95 million for this program should be sufficient to upgrade approximately 10,000 homes.

Other provisions of the new law create an urban development action grant program for special relief to the Nation's most severely distressed urban areas, and establish new discretionary grant programs geared to the needs of smaller cities. The 1977 act authorizes $3.5 billion for fiscal year 1978, $3.65 billion for fiscal year 1979, and $3.8 billion for fiscal year 1980.

President Carter plans to submit a message to the Congress on our Nation's urban problems during spring 1978. The message is expected to build upon the 1977 Housing and Community Development Act.

FINDINGS AND RECOMMENDATIONS

The nature of the community development block grant makes it difficult to monitor all benefits provided to older Americans. However, the Secretary of HUD can and should take further steps to provide a breakdown of such benefits on a demographic basis. Efforts should also be initiated to assure that the needs of older Americans are appropriately considered.

[26] Final regulations for the eligible activities, entitlement grants, and small cities program portions of the bill were issued on Mar. 1, 1978. Federal Register, pp. 8434-8490.

In addition, the program should be monitored by Congress and the Secretary to assure that provisions designed to improve the lives of the low- and moderate-income elderly are, in fact, being implemented effectively.

C. Title XX

Title XX of the Social Security Act is the major funding source for social services for all age groups.[27] Federal funds are provided to States, which have wide flexibility to determine services provided and eligibility for services.[28]

Federal law has placed a ceiling of $2.5 billion on Federal title XX expenditures,[29] but States may contribute to the program beyond their normally required matching share.

Total planned title XX expenditures, including State shares, was $3.354 billion during fiscal year 1976, the program's first year of operation. During fiscal year 1977, planned expenditures amounted to $3.409 billion. Roughly 70 percent of the $55 million increase represents State contributions above those required for Federal match.[30]

State plans submitted for fiscal year 1977 estimated the Federal share of State expenditures to reach 97.8 percent of the $2.5 billion Federal ceiling.[31]

During the first 2 years of the title XX program, concern was expressed by State officials responsible for services to the elderly that this spending ceiling was unrealistic when compared to social service needs and that allocations of title XX funds within some States did not adequately represent the needs of the elderly.[32]

It is difficult to determine age-related spending in title XX, as in other block grant programs. Information from States on characteristics of service recipients and types of services provided, however, can be useful in profiling some services provided to older Americans:

—An estimated 3.5 million individuals received title XX services during the second quarter of 1976. About 66 percent—or 2.3 million of these recipients—were adults of all ages. About 535,000 title XX service recipients were also beneficiaries of supplemental security income (of all ages).[33]

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[27] Public Law 93-647, effective Oct. 1, 1975. The program is now entering its third operational year.

[28] The law mandates no specific services, but requires States to provide services to meet five general goals. Federal funds are provided to States on a 75 percent matching basis, except for family planning, which is Federally matched at 90 percent. Services are generally available without charge to individuals with incomes up to 80 percent of a State's median income. For individuals with incomes between 80 and 115 percent of a State's median income, States have the option to charge small fees for services. States may provide services to individuals with incomes above 115 percent of median income at a fixed charge.

[29] Set by Congress in 1972, Public Law 92-512. During 1977, however, an additional $200 million was approved by Congress specifically for child day care services. (Public Law 95-171, approved Nov. 12, 1977.) This was considered a "one time only" addition, and was added to enable States to meet Federal standards for service.

[30] "Technical Notes, Summaries, and Characteristics of States' Title XX Social Service Plans for Fiscal Year 1977", technical note No. 1, Department of Health, Education, and Welfare, Mar. 1, 1977. States which planned to provide title XX services with State funds above their Federal match share included California, Connecticut, District of Columbia, Florida, Illinois, Massachusetts, Minnesota, New York, Oregon, Pennsylvania, and Vermont.

[31] Report cited in footnote 30. In fiscal year 1976, State plans, as submitted, estimated a Federal title XX expenditure equal to 97.2 percent of the $2.5 billion ceiling, but later analysis of actual expenditures indicated 1976 spending equal to 83.2 percent of the ceiling. While 41 States anticipated reaching their ceilings in fiscal year 1976, 17 States actually reached the limit, and another 9 spent over 90 percent of the ceiling. For fiscal year 1977, 44 States estimated full use of their title XX allotment. This number may be somewhat lower when actual uses of funds during the year are reported. The fiscal year 1979 budget proposed by the administration estimates that 48 States will reach the Federal spending ceiling.

[32] See report cited in footnote 18, p. 78, for a review of problems experienced in implementing title XX.

[33] "Social Services, U.S.A., Statistical Tables, Summaries and Analyses of Services Under Social Security Act Titles XX, IV-B, and IV-C for Fifty States and the District of Columbia," April-June 1976, U.S. Department of Health, Education, and Welfare, Office of Human Development Services, Administration for Public Services, Pub. No. (OHDS) 77-03300.

—Most States offer title XX services to beneficiaries of supplemental security income, but only about 11 percent of aged SSI beneficiaries received social services under title XX during the first 3 months of 1976.[34]

—The percentage of those aged persons eligible for SSI and receiving services varies from less than 1 percent in some States (Arizona and Indiana) to 39 percent in Maryland.[35]

The chart below shows that a significant number of States used title XX funds during 1976 for some of the services which are often cited as needed by older Americans.

The data represents actual expenditures for one 3-month period only, and shows services provided to adults of all ages, rather than the elderly exclusively. It also represents services provided at differing income levels in different States. It does, however, provide useful information.

NATIONAL SUMMARY OF 7 SELECTED SERVICES PROVIDED TO ADULTS [1]

Services	Number of States delivering services	Total number service recipients	Total spent by States	Cost per recipient (national average)	Percent of total recipients who are adults [2]	Percent of total recipients who receive SSI [3]
Chore services	35	194,679	$45,213,758	$232	92	75
Adult foster care	27	24,278	2,982,845	123	96	53
Adult day care	36	56,617	11,556,189	204	88	31
Protective services	45	133,408	14,816,731	111	93	27
Home delivered or congregate meals	32	37,894	2,643,651	70	95	33
Transportation	45	208,654	11,080,683	53	71	30
Homemaker services	49	152,781	37,087,217	243	89	52
Total, 7 selected services			125,381,074			
Total, all title XX services			671,659,878			

[1] Statistics from period April to June 1976 only. These services are not provided exclusively to older Americans, but they are services which are frequently cited as needed by older Americans. Elderly service recipients also receive other defined services which are not represented in this table. Source: Report cited in footnote 33.

[2] "Adults" would include all adult recipient categories: aged, disabled and blind SSI recipients; adults receiving other public assistance such as aid to families with dependent children and medicaid; and adults receiving services with or without charge at varying income levels.

[3] Nationally, approximately ½ of all SSI recipients are aged.

V. CRIME AND THE ELDERLY

Freedom from fear is a high priority for all Americans, and especially older Americans.

It is at or near the top of the list of concerns of millions of aged persons, whether they live in central cities, the suburbs, or rural communities.

Criminal activity frequently has a much greater and lasting impact upon the elderly, even though their crime victimization rate is lower than other age groups.

Victimization surveys, however, tell only part of the story. The Law Enforcement Assistance Administration, in its latest statement to this committee (see part 2 of this report), says:

[34] "SSI Recipients Receiving Social Services, January–March 1976," research and statistics note No. 1, Jan. 26. 1978, U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Program Policy and Planning, Office of Research and Statistics.

[35] During the period April–June 1976. Report cited in footnote 33.

> These lower victimization rates in no way minimize the severity of crime's effects upon older people. These statistics may cast a cold light on reality, but they do not measure the misery of fear, the apprehension, and the terror which keeps many of the elderly in our cities virtual prisoners in their homes and apartments. *More than one-half of the oldest persons surveyed indicated that they had limited or changed their patterns of living in order to minimize their risk of victimization.* [Emphasis added.]

Prior Senate Committee on Aging hearings,[36] as well as letters from elderly persons, also made it clear that large numbers of older Americans live under a form of house arrest—barricaded from the outside world. Fear is especially high among aged women (particularly those living alone), members of minority groups, and residents of medium or large cities.[37]

The only source for nationwide data correlating victimization to age is the national crime survey, compiled for the Law Enforcement Assistance Administration (LEAA) by the Bureau of the Census. This survey has been temporarily suspended because of questions about its reliability. However, better statistical facts about elderly victimization should result from the establishment of a single new bureau of criminal justice statistics. A Justice Department review group, operating under instructions from Attorney General Bell, is preparing recommendations for inclusion in the fiscal year 1980 budget. This new bureau would be charged not only with compiling data on the incidence of crime, but also with detecting trends for the purpose of taking early preventive actions.

Crime statistics may also understate the impact because many crimes are simply never reported by the elderly because of fear or retaliation. In addition, the pursuit of justice can be expensive for those living on limited incomes. And, the likelihood of successful prosecution, conviction, and imprisonment of the offender may be remote.

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[36] "Adequacy of Federal Response to Housing Needs of Older Americans," parts 5, 6, 7, 8, and 9.

[37] A brief but thorough review of the incidence and effect of crimes against the elderly is available in "Crimes Against the Elderly" by Barbara Puls McClure, Congressional Research Service, multilith No. 77-231 ED, Oct. 19, 1977.

TABLE A.—PERSONAL CRIMES: CHANGE IN VICTIMIZATION RATES FOR PERSONS AGE 12 AND OVER, BY SEX, AGE, AND TYPE OF CRIME, 1974 AND 1975

[Rate per 1,000 persons in each age group]

Sex and age	Persons in the group	Crimes of violence	Rape	Robbery			Assault			Crimes of theft	Personal larceny	
				Total	With injury	Without injury	Total	Aggravated	Simple		With contact	Without contact
MALES												
1974 rate	78,194,000	45.1	[1]0.1	10.3	3.3	7.0	34.8	16.0	18.8	108.7	3.0	105.7
1975 rate	79,184,000	43.5	[1].1	9.8	3.0	6.7	33.6	14.1	19.5	107.9	2.9	105.1
Percent change		−3.7	+80.0	−5.3	−8.7	−3.4	−3.3	[2]−11.9	+3.8	−.7	−3.4	−.6
12 to 15:												
1974 rate	8,384,000	69.2	[1].3	20.0	5.1	14.9	49.0	19.1	29.9	177.2	4.0	173.2
1975 rate	8,358,000	67.8	0	17.3	3.3	14.1	50.5	17.0	33.5	172.4	4.3	168.2
Percent change		−2.0	−100.0	−13.2	[3]−35.9	−5.5	+3.1	−11.1	+12.2	−2.7	+6.8	−2.9
16 to 19:												
1974 rate	7,777,000	93.5	0	17.3	5.6	11.7	76.2	37.1	39.1	183.6	4.4	179.2
1975 rate	7,853,000	87.2	[1].2	16.9	5.4	11.5	70.1	31.4	38.7	179.1	4.1	175.1
Percent change		−6.8	(4)	−2.1	−3.8	−1.3	−8.0	[3]−15.4	−1.1	−2.4	−6.7	−2.3
20 to 24:												
1974 rate	8,452,000	87.2	0	15.4	4.1	11.3	71.8	36.6	35.2	173.2	2.7	170.5
1975 rate	8,672,000	76.2	[1].3	14.5	4.6	9.9	61.3	28.5	32.8	169.0	4.5	164.6
Percent change		[2]−12.6	(4)	−5.5	+13.2	−12.2	[2]−14.6	[2]−22.2	−6.7	−2.4	+65.4	−3.5
25 to 34:												
1974 rate	14,213,000	49.9	[1].1	9.0	2.4	6.5	40.9	18.3	22.5	123.1	3.4	119.7
1975 rate	14,747,000	52.3	[1].1	9.0	3.5	5.5	43.2	17.7	25.5	125.2	2.1	123.2
Percent change		+4.7	0	+.5	+44.0	−15.6	+5.7	−3.7	+13.3	+1.8	[2]−38.4	+2.9
35 to 49:												
1974 rate	16,257,000	27.3	0	7.6	3.0	4.6	19.6	9.6	10.1	84.2	2.6	81.6
1975 rate	16,192,000	25.5	[1].1	5.7	2.0	3.8	19.6	8.4	11.2	82.7	2.4	80.4
Percent change		−6.6	(4)	[3]−24.7	[3]−34.4	−18.1	−.1	−12.1	+11.4	−1.8	−10.6	−1.5
50 to 64:												
1974 rate	14,546,000	15.8	0	5.4	2.5	2.9	10.4	3.9	6.5	54.7	2.0	52.7
1975 rate	14,622,000	17.9	0	6.4	2.6	3.8	11.4	4.3	7.1	55.3	2.2	53.2
Percent change		+13.2	0	+20.2	+5.2	+33.0	+9.6	+9.7	+9.5	+1.1	+6.4	+.9
65 and over:												
1974 rate	8,565,000	11.9	0	5.2	2.3	2.9	6.7	2.1	4.6	24.3	2.5	21.8
1975 rate	8,741,000	9.7	0	5.6	[1]1.0	4.6	4.0	2.3	1.8	27.1	2.2	24.9
Percent change		−18.6	0	+8.7	[2]−54.6	+57.5	[2]−39.7	+8.1	[2]−61.7	+11.7	−9.4	+14.1

TABLE A.—PERSONAL CRIMES: CHANGE IN VICTIMIZATION RATES FOR PERSONS AGE 12 AND OVER, BY SEX, AGE, AND TYPE OF CRIME, 1974 AND 1975—Continued

[Rate per 1,000 persons in each age group]

Sex and age	Persons in the group	Crimes of violence	Rape	Robbery			Assault			Crimes of theft	Personal larceny	
				Total	With injury	Without injury	Total	Aggravated	Simple		With contact	Without contact
FEMALES												
1974 rate	86, 368, 000	21.7	1.8	4.3	1.4	2.8	15.6	5.2	10.4	82.3	3.2	79.1
1975 rate	87, 548, 000	22.9	1.7	4.0	1.3	2.7	17.3	5.4	11.9	84.8	3.3	81.5
Percent change		+5.9	−9.3	−6.6	−9.7	−5.6	[2] +11.2	+5.0	[2] +14.2	+3.0	+1.5	+3.1
12 to 15:												
1974 rate	8, 143, 000	35.6	2.7	5.2	1.5	3.7	27.7	6.4	21.3	155.8	2.2	153.6
1975 rate	8, 084, 000	40.9	1.6	5.2	2.0	3.2	34.1	7.1	27.0	143.7	1.6	142.1
Percent change		+14.9	−40.6	0	+31.5	−13.1	[3] +23.1	+11.1	[3] +26.8	[3] −7.8	−26.4	[3] −7.5
16 to 19:												
1974 rate	8, 015, 000	43.0	4.9	5.5	1.4	4.0	32.7	10.7	21.9	136.7	3.1	133.6
1975 rate	8, 091, 000	41.9	4.6	4.5	1.6	2.9	32.7	11.7	21.0	145.6	2.5	143.1
Percent change		−2.6	−5.3	−16.9	+14.1	−27.4	+.2	+8.9	−4.2	+6.6	−17.3	+7.1
20 to 24:												
1974 rate	9, 157, 000	37.0	4.0	6.4	2.6	3.8	26.6	8.6	18.0	121.5	4.0	117.5
1975 rate	9, 333, 000	43.5	4.7	7.3	1.9	5.5	31.4	9.7	21.7	125.7	4.2	121.4
Percent change		[3] +17.5	+17.2	+14.5	−27.4	+42.7	+18.3	+13.3	+20.6	+3.4	+5.5	+3.3
25 to 34:												
1974 rate	14, 998, 000	27.9	2.5	5.2	1.8	3.5	20.2	7.1	13.0	90.1	1.9	88.2
1975 rate	15, 522, 000	26.8	2.3	3.7	1.1	2.6	20.8	6.0	14.8	95.2	3.7	91.5
Percent change		−3.9	−9.8	[3] −29.2	[3] −40.3	−23.5	+3.4	−15.5	+13.8	+5.6	[3] +88.1	+3.8
35 to 49:												
1974 rate	17, 526, 000	14.9	[1] .4	3.5	1.2	2.3	11.0	4.6	6.4	74.6	2.5	72.1
1975 rate	17, 496, 000	15.9	[1] .4	3.5	1.1	2.4	11.9	4.9	7.0	77.9	3.1	74.8
Percent change		+6.7	−2.4	+1.2	−6.7	+4.8	+8.7	+7.7	+9.5	+4.4	+25.7	+3.7
50 to 64:												
1974 rate	16, 301, 000	8.2	[1] .6	3.0	[1] .6	2.4	4.5	1.7	2.8	44.6	4.8	39.8
1975 rate	16, 454, 000	9.6	[1] .4	2.5	.9	1.6	6.7	2.5	4.3	47.7	3.2	44.5
Percent change		+17.2	−41.9	−17.9	+56.9	[3] −35.5	[3] +48.6	+46.2	+50.0	+7.1	[2] −32.4	+11.8
65 and over:												
1974 rate	12, 228, 000	7.0	[1] .3	3.0	1.7	1.3	3.7	1.2	2.5	20.2	4.1	16.1
1975 rate	12, 568, 000	6.5	[1] .1	3.4	1.3	2.1	3.0	.9	2.1	22.7	4.0	18.7
Percent change		−7.3	[3] −69.7	+13.8	−20.6	+56.8	−18.8	−23.5	−16.6	+12.2	−3.2	+16.1

[1] Rate, based on zero or on about 10 or fewer sample cases, is statistically unreliable.
[2] Change between rates for the 2 yrs was statistically significant at the 95-percent confidence level.
[3] Change significant at the 90-percent confidence level.
[4] Not defined.

Note: The absence of references reflects either no difference between rates or the lack of statistical significance for apparent change.

Source: "Criminal Victimization in the United States," a national crime survey report, U.S. Department of Justice, Law Enforcement Assistance Administration, National Criminal Justice Information and Statistics Service, February 1977.

TABLE B.—HOUSEHOLD CRIMES: CHANGE IN VICTIMIZATION RATES, BY AGE OF HEAD OF HOUSEHOLD AND TYPE OF CRIME, 1974 AND 1975

[Rate per 1,000 households]

Age of household head	Households in the group	Burglary				Household larceny			Motor vehicle theft		
		Total	Forcible entry	Unlawful entry	Attempted forcible entry	Total	Completed	Attempted	Total	Completed	Attempted
1974 rate	71, 834, 000	92.6	30.5	42.2	20.0	123.4	115.4	8.0	18.7	11.9	6.8
1975 rate	73, 137, 000	91.5	30.8	40.5	20.2	125.2	117.6	7.6	19.4	12.5	7.0
Percent change		−1.3	+1.0	−4.1	+1.2	+1.5	+1.9	−5.6	+4.0	+4.6	+2.7
12–19:											
1974 rate	1, 080, 000	217.3	59.2	115.9	42.2	204.8	186.9	17.9	54.0	33.5	20.5
1975 rate	1, 082, 000	214.2	39.6	130.1	44.4	221.6	204.8	16.8	32.7	21.1	11.6
Percent change		−1.4	[1]−33.2	+12.3	+5.4	+8.2	+9.6	−6.2	[1]−39.5	[2]−37.2	[2]−43.6
20–34:											
1974 rate	20, 459, 000	127.3	44.4	54.2	28.7	174.2	162 5	11.7	27.8	17.2	10.5
1975 rate	21, 270, 000	122.0	45.0	48.4	28.6	171.4	160.1	11.3	29.6	18.6	11.0
Percent change		−4.2	+1.4	[1]−10.7	−.3	−1.6	−1.5	−3.2	+6.5	+7.8	+4.3
35–49:											
1974 rate	18, 322, 000	99.0	30.6	49.8	18.7	145.9	137.9	8.1	20.8	14.2	6.6
1975 rate	18, 298, 000	101.4	32.7	50.0	18.7	149.0	140.7	8.3	21.7	14.2	7.5
Percent change		+2.3	+6.9	+.5	−.2	+2.1	+2.1	+2.7	+4.6	−.1	+14.5
50–64:											
1974 rate	17, 938, 000	69.0	23.7	30.3	15.1	88.9	82.2	6.7	14.2	8.7	5.6
1975 rate	18, 092, 000	68.1	23.6	29.4	15.2	94.1	88.6	5.5	14.9	9.8	5.1
Percent change		−1.3	−.6	−2.9	−.7	+5.9	[2]+7.8	−17.8	+4.7	+13.2	−8.6
65 and over:											
1974 rate	14, 036, 000	54.4	16.6	24.4	13.4	57.9	54.3	3.6	5.7	3.7	2.0
1975 rate	14, 395, 000	53.8	15.8	23.8	14.2	58.7	55.5	3.1	6.2	3.9	2.3
Percent change		−1.0	−4.7	−2.3	+6.0	+1.3	+2.3	−13.5	+8.6	+6.6	+13.0

[1] Change between rates for the 2 yrs was statistically significant at the 95-percent confidence level.
[2] Change significant at the 90-percent confidence level.

Note: The absence of references reflects either no difference between rates or the lack of statistical significance for apparent change.

A. LEAA: Its Activities and Its Uncertain Future

The Omnibus Crime Control and Safe Streets Act created the Law Enforcement Assistance Administration to administer a block grant program to assist States in improving law enforcement activities and criminal justice. Grants now total about $1 billion annually.

LEAA also provides discretionary "action grants." Examples include: (1) The National Committee on Crime and the Elderly, coordinated by the National Council of Senior Citizens (see p. 197 for further discussion); and (2) A $3.5 million National District Attorneys' Association economic crime project, targeted at consumer frauds and "bunko" schemes.

In addition, LEAA funds activities to obtain information about the incidence and effect of crimes against the elderly, improve environmental design of housing and neighborhoods to discourage crime, provide increased assistance to victims of crime, and promote greater involvement of the elderly in anticrime programs.[38]

Critics, however, have maintained that LEAA programs have been marked by excessive redtape and overhead costs. They further contend that earmarked funding for specific purposes dilutes LEAA's original goal to encourage novel and imaginative approaches to crime control and the administration of justice.

At the close of 1977, Attorney General Griffin Bell recommended to President Carter that LEAA be abolished and replaced by a Federal grant system resembling a form of general revenue sharing. LEAA's research and statistical functions would be centered in a National Institute of Justice under this proposal.[39]

Thus, the fate of LEAA—as well as the Federal approach to assist States and localities in crime prevention and judicial activities—is uncertain. Some of the Attorney General's recommendations could be implemented through a Presidential reorganization plan subject to House or Senate veto; others would require affirmative congressional action. Proponents of his general approach are expected to argue that it will cut redtape and enhance State and local discretion. Opponents may counter that special revenue sharing leaves Congress with too little control over the use of these funds for the achievement of certain national objectives.

B. New Steps Toward Assistance for Victims

Legislative developments in 1977 reveal increased congressional support for programs to compensate victims of Federal and State offenses, beyond the assistance now available in about half the States.

On January 30, 1978, the Senate adopted S. 1437—a comprehensive revision of the Federal criminal code—by a vote of 72 to 15. S. 1437 would establish a new victim compensation fund for victims or their survivors of Federal crimes of bodily violence.[40] The fund, which will be a depository for all Federal criminal fines as well as certain additional moneys, will compensate victims for actual pecuniary losses up to $50,000. Emergency compensation up to $1,500 is also made available.

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[38] A description of "Law Enforcement Assistance Administration Programs for Senior Citizens" is described in part 2 of this report.

[39] National Journal, Dec. 17, 1977, p. 1977.

[40] The included crimes are homicide, assault, kidnapping, hijacking, and sex offenses.

To qualify for assistance, victims must report the offense within 3 days of the occurrence, cooperate in prosecution of the offender, and subrogate recovery from other sources (including civil actions against the offender) to repaying the fund.

The House will consider legislation to revise the criminal code, including the victim compensation provisions, during 1978.

The House also passed legislation (H.R. 7010) on September 30, 1977, to extend Federal assistance to State victim compensation programs meeting minimum standards. H.R. 7010 would reimburse States for one-quarter of the first $25,000 in compensation paid to victims of violent crime. Reimbursement would cover medical bills, loss of earnings, and similar expenses. But, H.R. 7010 would not provide compensation for property loss or pain and suffering. The Senate plans to consider a similar bill (S. 551) in 1978.[41]

C. Activities of the National Committee on Crime and the Elderly

The National Committee on Crime and the Elderly is composed of several national organizations representing the elderly. Its goal is to develop a national program of crime prevention and victim assistance for the elderly.[42] This committee began full operations during 1977 after receiving funding from a variety of Federal and private sources.[43] Projects have been undertaken in six U.S. cities[44] with the following objectives:

—The mobilization of municipal services and community resources for elderly victimization prevention and assistance;
—The education of older persons about means to reduce victimization;
—The strengthening of "neighborhood watch" and other community-based crime prevention programs;
—The increased physical security of residences occupied by the elderly; and
—The establishment of immediate and comprehensive victim assistance programs.

The national coordination project, administered by the National Council of Senior Citizens, is charged with coordinating the efforts and activities of the six local projects. Additional functions include:

—Research and analysis of policies, procedures, and practices of the criminal justice system to identify guidelines to improve governmental response to elderly victims.
—Development of a model State victim compensation statute and implementing regulations.

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[41] Correspondence from David H. Marlin, Director of Legal Research and Services for the Elderly, to Senator James O. Eastland, chairman of the Senate Committee on the Judiciary, is reprinted in supplement 2, p. 272. This letter states the position of the National Committee on Crime and the Elderly in regard to S. 551.

[42] The National Council of Senior Citizens is the committee's national coordinator and research arm. Other members are the Urban Elderly Coalition, the National Retired Teachers Association/American Association of Retired Persons, the National Center on the Black Aged, the National Council on the Aging, the U.S. Conference of Mayors, the New York City Department for Aging, the New Orleans Council on Aging, the Milwaukee Community Relations/Social Development Commission, the Chicago Mayor's Office for Senior Citizens, and the Los Angeles Mayor's Office for the Aged.

[43] A $200,000 grant was received from LEAA for national administrative and coordination costs and for research on the interaction of elderly with the criminal justice system. HUD is funding evaluation of the local operating programs, which stress the relationship of crime to housing. Additional moneys are provided by the Community Services Administration, the Administration on Aging, and the Ford Foundation.

[44] New York City, District of Columbia, Milwaukee, New Orleans, Chicago, and Los Angeles.

—Development of training programs for both elderly persons and the police.

The national committee expects to complete its work in 1980.

FINDINGS AND RECOMMENDATIONS

Crime is a major problem affecting older Americans. As a group, they are especially vulnerable to violent crime because they are more likely to have poor vision, hearing loss, and limited mobility.

Many older Americans are also systematically preyed upon during the first part of each month when they receive their social security benefits, pensions, or supplemental security income checks.

Elderly persons are victimized in other ways besides violent crimes. Large numbers are bilked each year by con artists, swindlers, and others out to make a fast dollar. The aged are inviting targets for the unscrupulous because several conditions may make them vulnerable: loneliness, sadness caused by the loss of a spouse, fear of dying, and poverty.

The National Committee on Crime and the Elderly provides a means to obtain more detailed information to develop a comprehensive approach to the serious problem of criminal victimization of the aged. The Committee on Aging recommends that these activities be continued by LEAA or its successor.

The committee also urges that data-gathering techniques for criminal victimization be refined and perfected to insure that the information is reliable, accurate, and relevant.

The committee recommends that the Social Security Administration initiate additional efforts to alert persons about the availability of direct depositing of social security checks in banks and savings and loan associations.

VI. LEGAL SERVICES

In recent years, the Committee on Aging has initiated several actions to make legal representation more readily available for older Americans. A committee hearing conducted in conjunction with the American Bar Association convention in 1970,[45] for example, provided fresh new perspectives about legal problems confronting the elderly.

Beginning in 1974, the committee held hearings to improve legal representation for older Americans.[46] These hearings led to several major legislative enactments, including:

—The Tunney amendment to the Fiscal 1975 Labor-HEW Appropriations Act provided funding under the Older Americans Act to make legal representation more accessible for the elderly.

—The 1975 Older Americans Act Amendments[47] designated legal services as one of four priority services to be provided older

[45] "Legal Problems Affecting Older Americans," Senate Committee on Aging, St. Louis, Mo., Aug. 11, 1970. The Committee on Aging also conducted a hearing on "Legal Problems Affecting Older Americans" in Boston, Mass., on Apr. 30, 1971.

[46] "Improving Legal Representation for Older Americans," Senate Committee on Aging, part 1,. Los Angeles, Calif., June 14, 1974; part 2, Boston Mass., Aug. 30, 1976; part 3, Washington, D.C., Sept. 28, 1976; and part 4, Washington, D.C., Sept. 29, 1976.

[47] Public Law 94-135, approved Nov. 28, 1975.

persons under the title III State and community programs on aging.

—The 1975 amendments broadened title IV to include the training of lawyers and paraprofessionals to (1) provide legal counseling or (2) monitor the administration of programs for older Americans.

Several legislative and administrative developments in 1977 built upon these earlier solid achievements and offered the prospect of potentially far-reaching improvements for the elderly of tomorrow.

A. Statement of Understanding

On January 18, 1977, the Administration on Aging and the Legal Services Corporation signed a statement of understanding designed to promote cooperative relationships to increase the elderly's access to legal services.

Thomas Erlich, President of the Legal Services Corporation, sent a letter on February 10, 1977, to legal services program directors, saying:

> With limited resources, legal services programs are able to provide only limited access for all of the poor, including the elderly. As more funds become available, however, it is essential that all of us be sensitive to the special problems associated with delivering services to the elderly. We know that older persons with legal problems do not always find their way to some legal services offices and many of them may not even recognize that they have legal problems for which they can obtain help.

The statement of understanding has four major objectives:

(1) To make legal personnel more aware of the legal problems of the elderly;

(2) To inform older persons of their legal rights;

(3) To increase the number of legal personnel trained to work on behalf of aged clients; and

(4) To make legal services more accessible to senior citizens and to increase the number of communities providing legal services for older Americans.

AoA and the Legal Services Corporation agreed to undertake several actions to implement these goals. AoA, for example, will (1) make available to law schools, legal organizations and legal services programs materials developed by legal services model projects; (2) encourage State and area agencies on aging to explore ways in which bar associations, legal services programs, and the national network on aging can cooperate to expand legal services to the elderly; (3) develop a public education program designed to expand the awareness of older persons of their legal rights; (4) develop suggested curricula materials on legal services for the elderly; and (5) disseminate materials identifying funding sources for developing legal services for older Americans to State and area agencies on aging, legal services programs, bar associations, and law schools. The Legal Services Corporation has also agreed to initiate complementary actions.

Mr. Gary Kolb was named as special assistant for the legal program for the elderly at AoA. One of his major functions is to work with bar associations, legal aid societies, law schools, and others to encourage them to provide legal services for older Americans.

The section 308 model projects program provided $1.1 million in fiscal year 1977 to support legal services developers at the State level. Practically every State had a legal services developer at the end of 1977. Legal services developers will work with State and area agencies on aging to make legal representation more readily available for older Americans.

Through the third quarter in 1977, 160,882 individuals received legal services under title III (State and community programs on aging) of the Older Americans Act, including 21,541 members of minority groups and 55,056 low-income persons. Area agencies on aging used almost $3 million of title III area planning and social services funding for legal and related counseling services. In addition, area agencies on aging tapped into $2.3 million of other legal services funding. This provided legal services for 82,298 elderly, including 7,445 minority members and 42,188 low-income individuals.

The Administration on Aging made 20 training awards and model project grants for legal services during the 1975–78 period.[48]

B. Alternative Legal Services Delivery Methods

Legal services are particularly important for older Americans who perhaps more than any other age group rely upon Federal programs in terms of their day-to-day activities. But as things now stand, far too many elderly persons are denied access to the legal system.

In 1977, the Legal Services Corporation funded several projects to study alternative approaches to improve the delivery of legal services, including judicare, vouchers, prepaid plans, and contracts with private attorneys. Four of these projects served elderly clients as a primary target group.[49]

In 1978, the corporation plans to fund four additional projects:

—Philadelphia Bar Association will provide general legal services to aged clients through a panel of private attorneys.

—Bet Tzedek (House of Justice) is a private, nonprofit corporation.

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[48] Title IV-A training awards to: California Department on Aging to develop materials for community legal education and ways to coordinate local training resources; National Paralegal Institute to continue training and technical assistance for personnel and supervisors in agencies serving the elderly in the utilization of "community services advisors" (CSA's); Senior Adult Legal Assistance to complete materials on multidisciplinary training; George Washington University Law School to survey all law school efforts in training paralegals, developing substantive curriculum supplements and providing law students a clinical experience working with the elderly; Louisiana Center for the Public Interest to continue a sociolegal training program and complete dissemination of materials; Antioch Law School to disseminate law and aging curriculum through computer based system and the development of a programed instruction box; and University of Michigan for the continuation of development of materials for training nonlawyers, continuing legal education programs for training practicing attorneys, and training of law school students through clinical programs.

Section 308 model projects to: Senior Adults Legal Assistance to complete the development of model services delivery systems utilizing volunteer attorneys, paralegals and law students; Legal Research and Services for the Elderly to provide technical assistance to area agencies on aging in regions I, III, and IV, for community-based volunteer ombudsman programs, and develop and demonstrate operation of low-cost, self-sustaining legal services models; Public Interest Law Center of Philadelphia "to develop an effective long-term care system, utilizing coordination of lawyering, social science research, and community organization" People's Legal Services, Inc., to develop a legal services unit to serve elderly Indians and Chicanos; California Department on Aging to continue a statewide demonstration of the training and utilization of paralegals; Connecticut Legal Services to develop a statewide network of legal services for elderly poor by utilizing existing legal services programs and social services agencies; George Washington University Law School to establish a storefront law office for the elderly, utilizing law students and paralegals; Legal Services for the Elderly Poor (New York) to provide technical assistance to aging agencies in region II; Louisana Center for the Public Interest to provide legal services to the elderly, utilizing a sociolegal approach and providing technical assistance in Louisiana; University of Michigan Law School to provide technical assistance in Michigan and continue development of materials for dissemination; National Paralegal Institute to provide technical assistance to State and area agencies on aging on utilization and training of paralegals; National Retired Teachers Association/American Association of Retired Persons to demonstrate utilization of senior volunteers in District of Columbia offices for public entitlements; National Senior Citizens Law Center to provide technical assistance to regions V, VI, VII, VIII, IX, and X.

[49] For a description of these projects, see "Part 1—Developments in Aging: 1976," p. 192.

It will recruit volunteer attorneys to provide general legal services for the aged in Los Angeles.

—Legal Counsel for the Elderly, sponsored by the National Retired Teachers Association/American Association of Retired Persons, will make greater use of paralegals and volunteer attorneys in Washington, D.C.

—Consumer Group Legal Services will provide general legal services for the aged in Berkeley and Richmond, Calif.

In addition, the corporation plans other activities to improve legal representation for the elderly. Comprehensive training is planned for attorneys and paralegals concerning the legal rights of senior citizens. Specialized training for the supplemental security income programs is also available for legal services offices.

Moreover, the corporation has a research institute which is undertaking studies with important implications for aged clients, including guardianship laws and practices.

The legal services program first began in 1965. It now has 695 offices staffed by 3,000 attorneys, 1,000 paralegals, and 2,350 other support personnel. In 1957, approximately 1.25 million legal matters were handled by legal services personnel.

C. Legislative Developments

President Carter signed H.R. 6666, the Legal Services Corporation Act Amendments of 1977,[50] on December 28, 1977. The new law extends the Legal Services Corporation Act for 3 years, with an authorized funding level of $205 million for fiscal year 1978 and an open-ended authorization for fiscal years 1979 and 1980. Of special significance for the elderly, Public Law 95–222 directs legal services offices to adopt procedures to determine priorities for providing legal assistance to clients with special legal problems or those experiencing difficulty in obtaining legal services, including the elderly and handicapped.

S. 2394—sponsored by Senator Kennedy and Senator Church—represented another key legislative development for aged clients. This measure was based upon an earlier bill (S. 1282), introduced by Senator Kennedy on April 7, 1977. S. 2394, as revised, would authorize funding for State agencies on aging to support a staff person to (1) supervise and coordinate the delivery of legal services to the elderly and (2) provide legal advice and technical assistance on a wide range of issues.

Additionally, funding would be authorized for area agencies on aging to contract with local or statewide Legal Services Corporation programs or other legal services providers with demonstrated experience or capacity to deliver legal services to elderly persons with the greatest economic and social need. S. 2394 would authorize $75 million over a 3-year period: $20 million for fiscal year 1979, $25 milllon for fiscal year 1980, and $30 million for fiscal year 1981. Of this total, at least 80 percent would be allocated for State and area agencies on aging and up to 20 percent for resource centers. The centers would perform research, training, and technical assistance to groups providing legal services for the elderly.

[50] Public Law 95-222.

D. Subcommittee on Aging Hearing

At a hearing on the legal services for the elderly bill (formerly S. 1282 and now S. 2394 [51]), Senator Kennedy stated in his opening statement that the bill was "the result of a series of investigations that I undertook, including hearings in Boston and Washington, when I was a member of the Special Committee on Aging.[52] The bill attempts to meet the crucial demand for legal services among the elderly that was demonstrated in those hearings and in releated studies." [53]

Senator Thomas Eagleton, chairman of the Subcommittee on Aging of the Committee on Human Resources, said:

> Since its inception in 1966, the federally funded program of legal services for the poor has to some degree benefited the elderly. But the legal assistance under what is now the Legal Services Corporation is limited to those persons least able to afford legal assistance. Under regulations promulgated last year, the corporation has established a maximum income level for persons eligible to receive legal assistance of 125 percent of the poverty threshold—$3,500 for a single person and $4,625 for a family of two. . . . At present time, there does not appear to be any reliable data on the extent to which the Legal Services Corporation serves the elderly poor. The most commonly cited figure is 6 percent of the caseload, as contrasted with 17 percent of the Nation's poor being elderly.[54]

Tom Ehrlich, president of the Legal Services Corporation, saw the proposed legislation as assuring orderly development of legal services within the aging network:

> Several years ago, this subcommittee established legal services as a priority for use of funds under title III of the Older Americans Act. That step has resulted in increased activity in many parts of the country, but many agencies have been unwilling or unable to respond because of the limited funds available for the elderly in title III. The 3-year limit on use of these funds has created additional problems. S. 1282 recognizes these difficulties and attempts to deal with them by creating a separate, stable source for funding legal services for the elderly.[55]

The Administration on Aging urged a broad view of legal services:

> The term "legal services" is, however, inadequate to describe the advocacy services needed by the elderly. Such services are "legal" in the sense that they involve some aspect of the law, but they are much broader than the traditional "lawyer services." Indeed, whenever an older person seeks to secure his/her basic rights and privileges—whether

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[51] On Jan. 19, 1978, Senator Kennedy and Senator Church introduced a new version of a bill for legal services for the elderly.

[52] "Improving Legal Representation for Older Americans," hearings by the Senate Special Committee on Aging, part 1 (Los Angeles, June 14, 1974), part 2 (Boston, Aug. 30, 1976), parts 3 and 4 (Washington, D.C., Sept. 28 and 29, 1976).

[53] Opening statement by Senator Edward M. Kennedy before the Subcommittee on Aging, Senate Human Resources Committee, on S. 1282, "Legal Services for the Elderly," Oct. 4, 1977.

[54] Opening statement by Senator Thomas Eagleton, at hearings cited in footnote 53.

[55] Testimony by Thomas Ehrlich, President, Legal Services Corporation, before the Subcommittee on Aging, Senate Human Resources Committee, on S. 1282, "Legal Services for the Elderly," Oct. 4, 1977.

it be for efficient community services, suitable housing, medical care, personal freedom or elimination of discriminatory practices in employment—it is the art of advocacy, whether practiced by a lawyer, nonlawyer, or the older person himself/herself, that is needed. The Older Americans Act is predicated on such a concept of advocacy.[56]

A similar position was taken by a representative of the Legal Research and Services for the Elderly program:

> * * * legal advocacy is important enough to senior citizens, and to the social welfare of the country, to justify according it separate authorization and funding under the Older Americans Act. It deserves special treatment because legal advocacy is an essential tool for securing the whole range of income, health, housing, and social services entitlements so essential to the well-being of older persons. It deserves protection because lawyers, in pursuing the interests of their clients, sometimes threathen or antagonize political interests which, in turn, causes fiscal vulnerability.[57]

Asked why elderly persons need "special attention" in legal services and other social services programs, a representative of the National Senior Citizens Law Center testified:

> If the poor in general are underserved—and they are, the situation is especially grim for the elderly poor. To our knowledge, there are none among those charged with responsibility for providing legal assistance to the poor who would seriously dispute that adequate legal services to the elderly demands special "outreach" efforts.
>
> For one thing, the elderly have special mobility problems, including physical difficulties and fear of crime victimization, which pose greater problems for them than most other groups. Moreover, many elderly poor are unaccustomed to their new economic state. Until forced to live on fixed incomes, assailed by inflation, many present elderly were mainstream middle-income Americans, and consequently not adept in relating to the institutions upon which they are now dependent. The elderly may be unique among the poor in the degree of their inability to perceive bureaucractic violations of their rights, and reluctance to enter a legal services office as one of the "poor," seeking assistance.[58]

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Effective legal representation is a major need of older Americans. However, many elderly clients are forced to depend upon their own limited knowledge of the law when a legal problem arises. The low-income aged continue to be underrepresented in the legal services program. Moderate-income older Americans also experience difficulty in obtaining help when a legal problem

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[56] Testimony by Gary J. Kolb, Special Assistant, Legal Programs for the Elderly, Administration on Aging, at hearing cited in footnote 52.

[57] Testimony by David H. Marlin, Director, Legal Research and Services for the Elderly, at hearing cited in footnote. [52]

[58] Testimony by Edward C. King and Robert J. Cohen of the National Senior Citizens Law Center, before the Subcommittee on Aging, Senate Human Resources Committee, on S. 1282, "Legal Services for the Elderly," Oct. 4, 1977.

arises—whether it involves litigation, understanding the technicalities of Federal programs, or planning their personal affairs. They have too much income for the legal services program. Yet, they typically experience difficulty in paying a private attorney at today's going rate.

The committee commends the Administration on Aging and the Legal Services Corporation for initiating a statement of understanding. The committee requests that AoA and the Legal Services Corporation provide periodic progress reports of efforts taken to implement the four objectives of the statement of understanding.

The committee recommends that the Older Americans Act be amended to broaden current efforts by the AoA and other units within the "network" on aging to make legal representation more readily available. In addition the committee urges that:

—Legal representation should be made more readily available for older Americans under the Legal Services Corporation Act.

—The training of paralegals should be expanded.

VII. PROTECTIVE SERVICES

One major challenge confronting government at all levels—local, State and Federal—is the need to modernize the protection provided to mentally and physically infirm older Americans. A working paper on "Protective Services for the Elderly"[59]—prepared for the Committee on Aging by John J. Regan [60] and Georgia Springer[61]—provides fresh new perspectives on this timely and, at times, controversial subject. The authors conclude that conventional methods of caring for the helpless or dependent aged have proved, to a large degree, to be inadequate, whether they include family arrangements, community social services, charities, institutionalization or legal protection.

Protective services take many forms, including guardianship, conservatorship, emergency services, commitment, clinical services, community social services, and others. Protective services are distinguishable from other social services in that there is a potential for legal intervention. In a preface to the working paper, Senator Church said:

> Family members, practitioners, and the courts are called upon to make difficult, complex, and, at times, controversial decisions in determining when these services are necessary.[62]

The authors of the working paper estimate that perhaps 10 to 15 percent of all persons 60 or older—or 3 to 4 million older Americans—may now need protective services. They emphasize that historical factors as well as social changes have contributed to the elderly's growing need for protective services.

First, family and living patterns have changed markedly in a relatively short time. Years ago, the extended family concept was more typical. Children lived in the same communities as their parents. This

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[59] Issued in July 1977.

[60] John Regan is a professor at the University of Maryland Law School.

[61] Georgia Springer works as a staff attorney representing mental patients at Dorothea Dix hospital in Raleigh, N.C. Formerly, she was a staff attorney for Legal Research and Services for the Elderly, National Council of Senior Citizens.

[62] "Protective Services for the Elderly," a working paper prepared for the Senate Committee on Aging, July 1977, p. iii.

arrangement made it much easier for the children to care for their parents, if necessary. But today, children and parents are likely to be separated by vast distances in our fast changing society, making it impossible for the children to provide the necessary care.

Second, the need for protective services is likely to intensify in the years ahead, as our population becomes increasingly older. Today, close to 24 million Americans are 65 or over. By the turn of the century, this figure is projected to reach almost 31 million. Some of the sharpest percentage increases in our population will be among the older elderly—those 75 and above. These individuals are more likely to experience failing health, loneliness or chronic conditions which may make them—especially those living alone or bereaved by the loss of a spouse—require protective services.

Decisions concerning protective services involve Federal issues in many instances. Incompetency proceedings, for example, may raise basic constitutional questions. Senator Church observed:

> A determination of incompetency can have far-reaching as well as potentially devastating effects. An individual loses important rights, the most fundamental of which is the loss of liberty. Routine activities that most Americans take for granted—such as voting, charging a purchase at a local store, or conducting their personal affairs—are typically beyond the capacity of the incompetent. It is essential, therefore, that the legal proceedings have built-in safeguards to insure equity and justice for all concerned.[63]

However, the working paper concludes that fundamental notions of fair play are largely ignored or subverted. Notice, for example, may be vague or nonexistent. The authors give this description:

> The quality of this notice, however, is a different matter. It may simply order the person to appear in court at a particular date, time, and place to show cause why he should not be judged incompetent and subjected to an appointed guardian. Such notice does little to convey to the alleged incompetent what is at stake for him or what rights he has if he wishes to defend himself. He is not informed of the gravity of the charges against him nor of the consequences if he is found incompetent. He is not told of his rights to counsel, to present evidence, to cross-examine adverse witnesses, to a jury trial, or of other important evidentiary aspects of the hearing. Arguably, this notice is not "reasonably calculated under all the circumstances to apprise the proposed ward of the nature of the charges in order to afford him a real opportunity to present his objections." [64]

In their judgment, the hearing quite often becomes very one-sided.

> At the hearing, the alleged incompetent seldom is present. Many States permit the court to waive the requirement of presence if such action is in the best interests of the person. A doctor's certificate or affidavit stating that appearance in court might produce a harmful effect on the person usually is enough to induce the court to waive the person's attendance. The hearing then becomes one-sided. The judge hears only

[63] Page iii of working paper cited in footnote 62.
[64] Page 38 of working paper cited in footnote 62.

> the petitioner and the petitioner's lawyer. The court's determination will be based solely no the petitioner's evidence.[65]

Another important Federal question concerns the treatment of the institutionalized infirm elderly. Several measures have been enacted or expanded in the past 12 years to provide either directly or indirectly protective services for the elderly, including the Older Americans Act, medicare, medicaid, and title XX social services. Under title XX, for example, protective services are one of two universal services available without regard to any income test.

The working paper concludes that most institutionalized infirm aged patients do not return to the mainstream of community life. In some cases, institutionalization can produce destructive results for persons placed in nursing homes, foster homes, mental institutions, or other custodial arrangements. The authors stress that present public policies of relying principally on institutional care without providing other options are taking a tragic toll in many ways—economically, psychologically, and socially—for individuals and society.

> The cost to society is evident in several respects. First, institutional care is too infrequently rehabilitative. Too seldom are patients restored to function at a level appropriate to the patient's needs. Rather, as noted earlier, institutional care often accelerates deterioration and death, usually by passive indifference and occasionally by deliberate intent.
>
> Second, frequently the patient is confined to an institution involuntarily, either by court order following civil commitment proceedings or simply because the community offers no other means of care.[66]

The legality of involuntary institutional treatment has been challenged recently. In *Donaldson* v. *O'Connor*,[67] the Supreme Court held that it is unconstitutional for a State to confine an individual in an institution when the person is not dangerous and is capable of surviving alone or with the help of friends and family.

The authors also point out that guardianship proceedings are outdated and oftentimes of questionable constitutionality.

> No guardianship services are available for those with meager assets. State laws seldom provide for protective care short of guardianship. When they do, they fail, often, to provide that the arrangements respect the client's constitutional rights. Yet these laws provide the only alternatives available whenever legal intervention is sought to authorize care of an infirm elderly person.[68]

The working paper proposes several actions to reform State guardianship laws, including:

(1) A court should not order a person to be placed under a guardian until the individual has been screened by a psychiatrist and a social worker to determine the most appropriate placement, treatment, or assistance. In addition, the court should issue a written finding that the placement or intervention ordered is the least restrictive alternative possible consistent with the person's needs.

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[65] Page 38 of working paper cited in footnote 62.
[66] Page 7 of working paper cited in footnote 62.
[67] 422 U.S. 563 (1975).
[68] Page 13 of working paper cited in footnote 62.

(2) Guardianship laws should provide complete due process, including the right to counsel, to be present, to cross examine witnesses, and to appeal.

(3) State law should authorize public guardianship services for persons without financial resources to pay private guardians.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Issues related to protective services for the elderly are complex and, at times, controversial. Often, a delicate balancing process is involved. On the one hand, a society must preserve the ideals of personal choice, individual freedom, and respect for individual differences. But on the other hand, society has a duty to protect those unable to care for themselves and to protect itself from dangerous and destructive situations. These issues typically involve complex medical, legal, psychiatric, and other questions.

The committee recognizes that State courts, local units of government, and private agencies have traditionally borne the major responsibility for authorizing and providing protective services needed by infirm elderly persons. However, Federal funds increasingly finance many of these services.

The committee urges State legislatures to examine closely the model protective services and guardianship statutes included in the working paper on "Protective Services for the Elderly." Additionally, the committee recommends that legal services programs funded under the Older Americans Act work with State and local authorities to modernize and improve civil commitment procedures.

VIII. FOOD STAMPS

In 1977, the Congress extended the food stamp program for 4 additional years—through fiscal year 1981.[69] The extension was proceeded by months of debate, controversy, and speculation about the program's effectiveness.

The elderly poor have had a low participation rate in the food stamp program. Obstacles to their participation, as documented in hearings [70] and studies include: (1) unawareness of the program; (2) inability or unwillingness to comprehend the administrative redtape and application procedure; (3) unable to pay the purchase price for the stamps; (4) difficulties in travelling to apply for the stamps and receive them; and (5) the "welfare stigma" attached to the program.

In the past, it has been difficult to track the number of persons 60 and older who participate in the program as the U.S. Department of Agriculture (USDA) have recorded participant statistics by households and not by age groups. However, in 1977 the USDA and Bureau of the Census compiled a sketch of participation by the elderly, based on data collected in a 1975 survey:

—Seventeen percent (885,000) of all participating households (5.5 million) include one or more elderly persons.

[69] Public Law 95-113 (Food and Agricultural Act of 1977) was signed into law on Sept. 29, 1977.

[70] For additional details, see Senate Committee on Aging hearings, "Proposed USDA Food Stamp Cutbacks for the Elderly," Nov. 3, 1975, and "Effectiveness of Food Stamps for Older Americans," Apr. 18 and 19, 1977.

—Six percent (approximately 1 million persons) of the total food stamp participation (17 million) are persons 60 and over.
—Approximately 21 percent (1.1 million persons) in all participating households (5.5 million) receive social security.
—Approximately 17 percent (892,000 households) of all households (5.5 million) receive SSI (rough estimates show this to be appoximately 1 million aged participants).
—Approximately 17.9 percent (590,200 persons) of the elderly below the poverty level (3.3 million) participate in the program.
—The average gross monthly income for elderly household is approximately $223 as compared to the average of $298 for all households.
—Most households with elderly persons have $0 assets; 13 percent of households with elderly have assets over $500; and 2.5 percent have assets over $1,500.[71]
—Total monthly deductions (expenses for shelter costs, medical expenses, etc.) for elderly households are an average of $46 per month while all households average $77 per month;[72] and
—Approximately 4.3 percent of elderly household heads (33,000 persons) were working full or part time as compared to 18 percent of household heads aged 18–65 working full time and 5 percent working part time.

A. Legislative Actions

At hearings on the "Effectiveness of Food Stamps for Older Americans" before the Senate Committee on Aging, the Assistant Secretary for Food and Consumer Services of the Department of Agriculture, Carol Tucker Foreman, said:

> The most important provision in the proposal for improving access to the program by the elderly is the elimination of the food stamp purchase requirement. The purchase requirement now operates as a barrier that prevents some elderly from obtaining the food stamp benefits to which they are legally entitled. Studies conducted by the Maryland State Office of the Aging in 1975–76 and by the University of Mississippi in 1974 found that the purchase requirement posed a significant obstacle for elderly persons.[73]

Senator John Melcher, who presided at the hearings, concurred and said that he had learned that "many elderly people now do not have the resources to pay $35 or $40 at one time to buy their way into the food stamp program.[74]

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[71] There is no assets test in the current law. However, the regulations require that households have less than $1,500 in assets, $3,000 for households of two or more persons in which at least one person is age 60 or over. Exempted from the assets test are the full value of the home and lot, a car, a second car if needed for employment, all household goods and personal effects, all income-producing property, all life insurance policies and pension funds, tools, and machinery needed for work, and resources whose face value is not accessible to the households such as irrevocable trust funds.

[72] Households get itemized deductions for: taxes and other mandatory payroll withholding, work-related expenses up to $30 a month, medical costs, tuition and fees, child care costs to allow a household member to work, court-ordered alimony or support payment, unusual expenses due to disaster or casualty loss, and shelter costs (including rent, utilities, mortgage payments, and taxes) to the extent that they exceed 30 percent of income after other deductions are subtracted.

[73] Testimony by Assistant Secretary for Food and Consumer Services (USDA) Carol Tucker Foreman before the U.S. Senate Special Committee on Aging hearings on "Effectiveness of Food Stamps for Older Americans," Apr. 18, 1977.

[74] Opening statement by Senator John Melcher at U.S. Senate hearing cited in footnote 73.

Many witnesses supported elimination of the purchase requirement as a priority proposal for making the program more accessible to elderly poor. Additional recommendations included:

The American Association of Retired Persons/National Retired Teachers Association:

> In the long run our associations would prefer to see a guaranteed minimum income raised to a level which would render the food stamp program unnecessary for the majority of elderly persons. For the elderly in particular, food stamps are not adequate substitutes for real income. Even if outreach efforts were redoubled, distribution problems resolved, and the purchase requirement eliminated, we suspect that large numbers of elderly persons would still not participate in the program for one reason or another.[75]

The National Council of Senior Citizens reinforced its support of the elimination of the purchase requirement and the implementation of a standard deduction if an additional shelter deduction were allowed. The Council statement said:

> An excess housing allowance based on the actual outlays of households provides an excellent alternative to regionalization of benefits, and one that is perhaps even better, since it provides cost-of-living distinctions within areas as well as between areas. In addition, the Bureau of the Census 1975 survey of housing indicates that the elderly, 65 years of age and over, represent a disproportionate number of households within low-income groups in almost all areas of the country, particularly in the Northeast and North Central United States. . . . The evidence indicates that use of an excess housing allowance will most likely favor the least well off benefit recipients to whom an extra dollar means more than to those who are slightly better off.[76]

Simplifying application procedures for recipients, especially the elderly, was a major concern by the National Center on Black Aged. NCBA stated:

> The forms are complex. The elderly as well as the elderly black have less education and less understanding of how to accumulate the necessary information for these complicated forms. Thus, we strongly support the provisions in S. 1272 [77] that provide for application and annual certification of SSI and social security recipients at local or district social security offices. I will say, however, I don't know whether that solves a problem for the rural black who still will have a distance to go to their district social security offices. Also, having the elderly apply at the local or district social security offices, will have a better opportunity for improving outreach efforts.[78]

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[75] Testimony by Faye L. Mench, legislative representative, at a hearing cited in footnote 73.
[76] Testimony by William R. Hutton at a hearing cited in footnote 73.
[77] For information about S. 1272, see section B, "House-Senate Action," below.
[78] Testimony by Arlene T. Shadoan, Legal Counsel and Director, Federal and State Programs, National Center on the Black Aged, Inc., at hearing cited in footnote 73.

The National Council on the Aging:

> While simplified administrative procedures and elimination of the purchase requirement would remove many obstacles to the full use of the food stamp program, a strengthened outreach program is required to assure that the program serves the eligible older population. Too many times NCOA has seen vital human assistance programs pass the elderly by because of insufficient outreach efforts. The abandoned elderly in inner city rooming houses or isolated rural areas are most likely to need help but least likely to find it. We must encourage vigorous outreach and strengthened cooperation between food stamp and other social services offices, such as local social security offices. But we must also work to reach those individuals outside of all the Federal assistance networks.[79]

B. House-Senate Action

The National Food Stamp Reform Act for the Elderly (S. 1272)—introduced by Senators Frank Church and John Melcher on April 7, 1977—advanced three provisions to make the food stamp program more accessible to the elderly:

(1) Eliminating the food stamp purchase requirement for all recipients;

(2) Permitting supplemental security income (SSI) and social security recipients to apply for and be certified for food stamps at their local or district Social Security office; and

(3) Allowing SSI and social security recipients to be recertified for eligibility on an annual basis.

Modified provisions of the Church-Melcher bill were included in the Senate version of the Food and Agricultural Act of 1977, and in the compromise act sent to the President and signed into law on September 29, 1977 (the Food and Agricultural Act of 1977, Public Law 95–113).

Several other provisions also benefit the elderly:

—A standard deduction of $80 for all potential recipients which will simplify the application process and provide for generous deductions for most elderly whose itemized deductions have averaged $46 in the past.

—An additional deduction of up to $75 for utility costs and dependent care expenses.

—A simplified application process for SSI recipients by allowing a single interview at Social Security district office for both the SSI and food stamp programs (the act allows for the Secretary of USDA to offer this same option to social security recipients).

—Allowing recipients to designate an authorized representative to apply for stamps, be issued stamps and/or shop with stamps on their behalf, a provision of special importance to those elderly who are not ambulatory.

—Discontinues a provision of the law which required a household to have cooking facilities to be eligible for foodstamps, and therefore, enhances the possibility of eligiblity for those elderly who

[79] Testimony of Peter Meek, board of directors, National Council on the Aging, at hearing cited in footnote 73.

live in single-room occupancy hotels or other one-room situations with no cooking facilities.

—Allowing food stamp recipients who are elderly or disabled to pay for meals delivered by public or private, nonprofit meal delivery programs.

—Reimbursement for expenses to volunteers and workers is not counted as income in determining one's eligibility for food stamps.

—A requirement that all eligible households receive their stamps within 30 days of application and that households in immediate need may receive expedited service; and

—An exemption for persons aged 60 and over from the work registration requirement.

Although these provisions were enacted in September 1977, final regulations are not expected from the USDA until summer or fall 1978.

IX. PENSIONS: NEW STEPS TOWARD ASSURING ADEQUATE RETIREMENT INCOME

Federal agencies took several steps to implement fully the Employee Retirement Income Security Act (ERISA) during 1977, including rulings to clarify the standard of care for pension trustees and to cut paperwork for employers. In addition, the Department of Labor initiated the largest action under ERISA's protective provisions against trustees of the Teamsters Central State Pension Fund. However, major issues remain to be resolved by the Congress in the coming months.

New information also indicates a need for action in other areas related to retirement income security, and particularly to the pension systems administered by all levels of government. President Carter announced his intention of creating a commission, charged with reporting its recommendations within 2 years, on means of readjusting and improving the interrelationships between public and private sector retirement and disability systems.

A. ERISA: Performance and Promise

ERISA established minimum vesting (a nonforfeitable right to a pension after an employee works a minimum number of years, even though he may later leave the job) standards; pension termination insurance; minimum funding requirements; stronger safeguards for the investment of pension trust funds; and reporting and disclosure requirements to convey essential information to workers and pensioners. In 1977, the Congress and the executive branch initiated several actions to clarify the provisions in the 3-year-old law, as well as to resolve major problem areas for pension plan administrators, employers, and others.

1. PAPERWORK BURDENS

Many employers—particularly small businessmen—objected to the act's paperwork requirements as being costly and burdensome. Some claimed they were forced to terminate pension coverage for their employees because of "redtape."

A 1976 Commission on Federal Paperwork study agreed that many of the complaints were justified. The Commission advanced 14 recommendations to "eliminate excessive paperwork requirements in this very necessary and laudable program." [80]

The Department of Labor and the Internal Revenue Service implemented several of these recommendations in 1977, including the elimination of duplicate forms and adoption of concurrent reporting deadlines. Congressional committees are expected to act in 1978 on other Commission proposals requiring legislation.

2. MULTIEMPLOYER PLAN INSURANCE

Another issue receiving attention in 1977 was the adequacy of the multiemployer plan insurance provision in ERISA. Nearly 35 million workers are covered under ERISA, including 8 million participants in multiemployer pension plans.[81]

A Pension Benefit Guaranty Corporation assesses these plans at 50 cents per employee annually to provide protection in the event of a plan termination. ERISA, however, made this coverage discretionary until January 1978.

PBGC alerted the Congress in 1977 that two major problems existed:

(1) The assessment formula was inadequate to provide protection to employees participating in these plans.

(2) Mandatory coverage of multiemployer plans in 1978 may cause pension plan failures, particularly in declining or economically troubled industries.

Congress enacted legislation [82] late in 1977, deferring mandatory coverage of these plans until July 1, 1979. Congress will determine whether the rate needs to be adjusted after receiving a report (due on July 1, 1978) from PBGC.

3. RELATIONSHIP OF ERISA TO SECURITIES LAWS

In *Daniels* v. *International Brotherhood of Teamsters*, the Federal Court of Appeals for the Seventh Circuit held that an employee's interest in a pension fund is a security subject to the antifraud provisions of the Federal securities law. The significance of this holding is that the Securities and Exchange Commission would be involved in the regulation of private pensions, as well as the Department of the Treasury and the Department of Labor. In addition, the ruling would apply ERISA's disclosure standards before the enactment of the law in 1974. The decision is now being appealed to the Supreme Court.

B. Proposals for a Single Administering Agency

Congress continued to receive numerous complaints about problems caused by dual administrative responsibility of ERISA. The Department of the Treasury administers tax aspects of the law, and the Department of Labor is concerned with employee protection.

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[80] "The Employee Retirement Income Security Act," a report of the Commission on Federal Paperwork, Dec. 3, 1976, p. 1.

[81] A multiemployer plan is when a group of employers within an industry pay into a single pension plan. Multiemployer plans are concentrated primarily in the trucking, construction, retail, printing, shipping, and mining industries.

[82] Public Law 95-214, approved Dec. 19, 1978.

A July 1977 General Accounting Office report criticized the Department of Labor's administration of ERISA.[83] This report prompted a hearing by the Human Resources Labor Subcommittee in October. Senator Harrison Williams, chairman of that subcommittee as well as the full committee, said:

> The inefficiency, waste, duplication of effort, delay, and expense of the present administrative systems under the pension reform act have hurt the very people we wanted to protect. . . . In 1977 we are told, in a Department of Labor press conference last week, that the ERISA program was badly mismanaged from the start, that the agencies have often gone their own separate ways with little or no coordination, resulting in delay, confusion and inadequate protection of the rights of participants.

Support for a single agency to administer ERISA gained impetus in 1977. Representative John Dent, the chairman of the House Subcommittee on Labor Standards, and its ranking minority member, Representative John Erlenborn, sponsored H.R. 4340 to create an Employee Benefit Administration. This new unit would be responsible for all ERISA administrative functions.

Senator Jacob Javits, the ranking minority member of the Human Resources Committee, called for a different administrative approach, consolidating all Department of Labor and IRS functions within a Pension Security Administration. Senator Javits said that this new agency could also eventually assume responsibility for extending ERISA-type protection to State and local pension plans, Federal pension systems, employee stock ownership plans, and conceivably the duties of the Social Security Administration.[84] He further proposed that a Pension Claims Review Board be established to investigate, try, and decide participant claims arising under ERISA's participation, vesting, benefit accrual and funding provisions.

C. Governmental Pension Commission

President Carter announced in the fiscal year 1979 budget that he would establish a commission to examine the civil service retirement system, other Federal retirement programs, State and local pensions, and private pension plans. A major focus of the commission will be the interrelationships among public and private retirement, survivor and disability systems and the implications of retirement issues for the future. The Administration plans to advance legislation for a 2-year study by the commission. The work of the commission will be closely coordinated with the activities of the Social Security Advisory Council which will be appointed during the year.

Several disturbing reports emerged in 1977 about the actuarial soundness of public and private pension plans. The General Accounting Office, for example, examined seven major Federal retirement programs, concluding that the costs and liabilities were not fully

[83] "Efforts to Implement the Employee Retirement Income Security Act of 1974 by the Department of Labor," Report to the Senate Committee on Human Resources by the Comptroller General of the United States, July 6, 1977, HRD-77-99.

[84] For further information, see Aug. 4, 1977 Congressional Record, pp. S. 13528-32 and Sept. 30, 1977 Congressional Record, pp. S. 16057-8.

recognized and funded. GAO [85] called upon Congress to develop a single overall Federal pension policy:

> . . . In 1976, seven of the Government's retirement systems paid over $15.6 billion to retirees and survivors of deceased employees and retirees—an increase of $10 billion since 1970. The systems also reported liabilities exceeding $320 billion for which less than $44 billion has been set aside in Federal trust funds.
>
> The Congress should enact legislation requiring that the full cost of Federal retirement systems be recognized and funded and that the difference between currently accruing cost and employee contributions be charged to agency operations.
>
> Federal retirement systems' funding requirements vary, and in most cases are less stringent than those imposed by law on private plans. . . . For the civil service retirement system alone, unrecognized retirement costs in 1976 amounted to an estimated $7 billion. . . .
>
> GAO further recommends that the Congress establish an overall Federal retirement policy to guide retirement system development.[86]

The House Pension Task Force is scheduled to issue a report on State and local pension plans in 1978. Major issues include unfunded liabilities and possible conflicts of interest which may arise when pension plan administrators invest pension funds in the bonds of a government-employer.

Questions have also been raised about the soundness of the private pension system. An article in the November 1977 Fortune magazine estimated that (a) 10 of America's top 100 corporations had pension liabilities exceeding one-third of their net worth, and (b) the total unfunded pension liabilities of all U.S. corporations may be as high as $100 billion. However, other authorities have challenged these estimates.[87]

D. Other Developments

On February 1, 1978, the Department of Labor instituted the largest action to date under ERISA civil provisions which hold pension trustees liable for personal restitution when fund losses are caused by imprudent action. This lawsuit was brought against Teamsters Union President Frank Fitzsimmons and 18 other former trustees and present administrators of the Central States Pension Fund. The Labor Department estimated that the fund, which provides retirement coverage to 450,000 trucking industry workers, had lost at least $125 million because of mismanagement.

During 1978, the Supreme Court is expected to resolve the question of how women should be treated for pension actuarial purposes. At present, most plans require women to make larger contributions for the same benefits, or give lesser benefits for equal contributions, in comparison to male coworkers Many actuaries contend that this is a permissable recognition of the longer female lifespan, but others argue that the practice is inherently discriminatory.

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[85] "Federal Retirement Systems: Unrecognized Costs, Inadequate Funding, Inconsistent Benefits," Report to the Congress by the Comptroller General of the United States, FPCD-77-48, Aug. 3, 1977.

[86] Pages i–ii of report cited in footnote 85.

[87] For example: "Pension Plans—Is the Sky Really Falling?" Pension World, February 1978, pp. 7–14.

FINDINGS AND RECOMMENDATIONS

Many of the problems which were preventing full implementation of ERISA have been resolved. However, congressional action is required during 1978 to alleviate the continuing difficulties caused by the present division of administrative responsibility. This should be accomplished either by clearly delineating the roles of the Departments of Labor and the Treasury, or by establishing a new single adminstrative body.

Serious questions have also been raised about the unfunded liabilities of both private and public employee pension plans. Congress should fully investigate these charges, and in particular should establish sounder and more uniform practices for Federal retirement programs.

X. ACTION PROGRAMS

Congressional support for ACTION's older American volunteer programs continued to grow during 1977. Increased funding for the retired senior volunteer program, the foster grandparent program, and the senior companion program was approved for fiscal year 1978, and the Committee on Aging took testimony on the effectiveness of all three programs during field hearings throughout the year. Retired senior volunteers and senior companions are playing increased roles in the delivery of services to homebound elderly, and foster grandparents working with children with special needs expanded their activities during the year.[88]

A. Program Growth and Responsibilities

The retired senior volunteer program, which provides volunteer opportunities to individuals age 60 and over, had approximately 225,000 volunteers enrolled during 1977.[89] Volunteers were engaged in a wide variety of activities and services, and ACTION reports that they served mainly in four basic service areas: health and nutrition services, community service, education, and economic development and income service. Many volunteers served as aides at nutrition sites and in other direct service programs funded by the Older Americans Act.[90]

Approximately 16,500 foster grandparents worked with 41,000 children with special needs in 195 different projects during 1977.[91] Individuals age 60 or over with low incomes are eligible to be foster grandparents, and participants receive a stipend of $1.60 an hour. Foster grandparents normally work up to 20 hours a week, and the stipend thus helps to supplement income.

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[88] See ACTION's report on program activities in part 2 of this report.

[89] RSVP is authorized under title II of the Domestic Volunteer Service Act of 1973, as amended. Section 201 authorizes grants and contracts for volunteer service projects in order to help retired persons to avail themselves of opportunities for volunteer service in their community.

[90] For a description of services funded by the Older Americans Act, see chapter VIII, p. 113.

[91] The foster grandparent program is authorized under title II of the Domestic Volunteer Service Act of 1973, as amended. Section 211(a) authorizes grants and contracts for volunteer service projects to pay part or all of the cost of development and operation of projects (including direct payments to volunteers) designed to provide opportunities for low-income individuals age 60 or over to provide supportive person-to-person services in health, education, and welfare and related settings to children with exceptional needs.

According to ACTION, 60 percent of foster grandparents work with mentally retarded and physically handicapped children. About one-quarter provide services to children with special learning problems under the supervision of classroom teachers. Others participate in programs to aid runaway youth, abused children, and children under court supervision.

The senior companion program is designed to provide further service opportunities to low-income elderly. Eligible participants must be age 60 or over and have low incomes. Senior companions provide services to adults with special needs, and receive a stipend of $1.60 an hour for up to 20 hours of work a week.[92]

During 1977, 2,880 senior companions provided services to about 10,000 older Americans in private homes, nursing homes, and other residential institutions. There are now 46 senior companion projects in 37 States and Puerto Rico. Almost 70 percent of all senior companions provided services to older Americans confined to their homes.

B. Fiscal Year 1978 Appropriations

Congress approved funding of $20.1 million for the retired senior volunteer program for fiscal year 1978—$1.1 million above the 1977 funding level.

Fiscal year 1978 appropriations for the foster grandparent program were $34.9 million—$900,000 above the 1977 funding level.

The senior companion program was funded at $7 million for 1978—almost double the fiscal year 1977 funding of $3.8 million.

C. Changes Proposed for RSVP

An evaluation of all programs administered by ACTION, conducted by a committee of private citizens chartered by the ACTION agency, found what the evaluation committee termed a lack of direction in the retired senior volunteer program and inattention to its development in recent years by ACTION. The citizen's review committee asserted that too many RSVP volunteers worked with people who were not members of any minority community and in settings where the income level was above the poverty line.[93]

The evaluation committee found that even though it was clear the involvement of RSVP volunteers in programs not serving poverty problems was allowed under existing law, it did not believe that this should be the primary direction of the program.

A number of authorities in the field of aging, however, have questioned the underlying assumptions and techniques of the evaluation, and congressional support for RSVP apparently continues to remain high. Several members of both Houses have protested the administration proposal, as advanced in its fiscal year 1979 budget request, to reduce RSVP funding from $20.1 million to $15.4 million.

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[92] The senior companion program is authorized under title II of the Domestic Volunteer Services Act of 1973, as amended. Section 211(b) authorizes grants and contracts for volunteer service projects designed to provide services to persons, other than children, having exceptional needs, including services such as senior health aides to work with persons receiving home health care, nursing care, or meals-on-wheels or other nutritional services, and as senior companions to persons having developmental disabilities or other special needs for companionship.

[93] Section 223 of the Domestic Volunteer Services Act of 1973, as amended, requires the ACTION Director to take appropriate steps to insure that special efforts are made to recruit, select, and assign qualified individuals 60 years and older from minority groups to serve as volunteers.

XI. TRANSPORTATION: POSITIVE DEVELOPMENTS

The most significant transportation development of the year for older Americans was the decision of Secretary of Transportation Brock Adams to require that all new transit buses purchased with Federal assistance must be fully accessible to elderly and handicapped individuals. This overdue implementation of equal transit rights will eventually result in a transit network which is more comfortable, convenient, and attractive to all riders.

There were other positive developments:

—Legislation was enacted enabling airlines to offer discount fares to the elderly.

—The Senate, in approving new transit legislation, gave explicit emphasis to the continued need for special transportation services.

—A no-fault insurance bill promising premium reductions for older drivers was aired in Senate hearings.

—Several major metropolitan areas undertook innovative and comprehensive strategies to better meet the needs of the transportation-disadvantaged.

Nonetheless, problems persist. Senate Committee on Aging hearings revealed that many special transportation programs for the elderly were facing cutbacks or termination due to rapid increases in insurance rates and restrictions placed upon their operations by insurance underwriters. Many special transportation services also continued to operate in a noncoordinated, duplicative manner. And the lack of adequate transportation in rural areas was a continuing difficulty for the elderly, although President Carter's proposals for a revamped national transportation program proposed some relief.

A. The Transbus Mandate

As 1977 began, controversy continued as to whether bus design standards issued by the Urban Mass Transit Administration (UMTA) in July 1976 met the congressional requirement, enacted in 1970, that "elderly and handicapped persons have the same right as other persons to utilize mass transit facilities and services".[94] Shortly after taking office, Department of Transportation (DOT) Secretary Brock Adams deferred implementation of those regulations and reopened the accessibility debate to public hearings. In March 1977, the General Accounting Office (GAO) issued a report strongly critical of UMTA's failure to implement congressional policy in this area.[95] In April 1977, Committee on Aging Chairman Frank Church, joined by Senator Lawton Chiles, wrote to Secretary Adams to urge that UMTA's revised regulations heed congressional policy. Their letter stated:

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[94] For background on Transbus through 1976, see *Developments in Aging: 1976*, part 1; pp. 95–98.

[95] *Mass Transit for Elderly and Handicapped Persons: Urban Mass Transportation Administration's Actions;* report of the Comptroller General of the United States, CED-77-37, March 25, 1977. This report stated: "Before 1975, the Urban Mass Transportation Administration was passive in carrying out this law. . . . Some recent regulations should prove helpful, but more can be done (p. i). In November 1970, 1 month after the act was amended, UMTA issued instructions requiring applicants for capital grants to make reasonable efforts in planning and designing their transportation facilities and equipment to provide mass transportation that elderly and handicapped persons could effectively use. However, until late in 1974, UMTA made only minimal efforts to insure that these instructions were carried out (p. 5). UMTA officials stated that even though section 16 requirements have been in the act since October 1970, UMTA has just recently started to enforce these requirements. One regional director noted that late in 1974 UMTA began to emphasize transportation needs of elderly and handicapped persons, apparently in response to external pressures (p. 9). UMTA has been reluctant to approve capital grants to several mass transit operators to make their systems fully accessible for elderly and handicapped persons where a genuine interest has been expressed for doing so" (p. 19).

> America's technological capability is surely sufficiently developed to provide transit which can be easily and safely utilized by the overwhelming majority of Americans, no matter what their age or physical handicap. We can see no reason why, when tax dollars provide 80 percent of the capital cost of these buses, taxpayers should be excluded from their use.[96]

On May 19, Secretary Adams announced that, as of September 30, 1979, all new public transit buses purchased with DOT assistance must:

—Have a floor height of not more than 22 inches;
—Be capable of "kneeling" at stops to 18 inches; and
—Be equipped with a ramp for boarding.[97]

This decision recognized that fully accessible vehicles were both economically sound and consistent with congressional intent that the Nation should not develop separate transit systems, one for the able-bodied and one for the elderly and handicapped. The 1979 implementation date was set to afford manufacturers sufficient time for final testing and tooling. However, given the 12-year turnover time for bus fleets, fully accessible transit will not be entirely in place until about 1990 in most communities. Thus, while the Transbus decision is of long-term significance, special transit services have an especially important role to fill during this transition period, and will have a continuing, but more limited, function as America enters the 21st century. (See section B for Senate clarification on this point during debate on S. 208.)

B. Other Positive Developments

Reduced Air Fares.—During 1977, Congress overrode Civil Aeronautics Board (CAB) prohibitions against special discounts for specific population groups. It explicitly permitted, in amendments to the Federal Aviation Act, reduced fares on a space-available basis to retired persons more than 60 years of age, and to all individuals 65 or older.[98] When introducing legislation for that purpose earlier in the year, Committee on Aging Chairman Frank Church had enumerated the merits of standby discounts for older Americans:

> First, the average load factor on the airlines is only 50 percent. As our energy shortages become more acute, . . . they must fly as close to full capacity as possible.
>
> Second, senior citizens are precisely the group that could make use of the airlines during offpeak hours when travel is the lightest.
>
> Third, senior citizens make up only about 5 percent of all domestic airline passengers but 10 percent of our population.
>
> Fourth, many senior citizens do not fly because they cannot afford to do so.
>
> Fifth, when fares are reduced the senior citizens will take advantage of the reductions. . . . When Hawaiian

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[96] The full text of this Apr. 15, 1977, letter, and Secretary Adams' reply, is printed in supplement 1, item 1, p. 255.
[97] The text of Secretary Adams' decision is reprinted in supplement 2, p. 257.
[98] Public Law 95-163, section 8(a); Nov. 9, 1977.

Airlines provided reduced air fares, they had a 38-percent increase in the number of passengers, but a 400-percent increase in senior citizen passengers.[99]

In November 1977, Allegheny Airlines became the first domestic carrier to apply to the CAB for permission to offer a one-third discount to elderly passengers.[100]

Senate Action/Carter Proposals.—In June, the Senate passed S. 208 (The National Mass Transportation Assistance Act of 1977), which contains $5.8 billion in new authorizations for mass transit construction and operating expenses. During Senate debate, Senator Harrison Williams offered an amendment to delete a section of the bill which clarified the congressional intent that all vehicles purchased with Federal assistance be accessible to the elderly and the handicapped—a section no longer required in light of the Transbus decision. Senator Lawton Chiles made an inquiry for the purpose of clarifying the intent of the Senate as to the future role of special transit programs, particularly the section 16(b)(2) program of grants to nonprofit providers:

> Mr. CHILES. . . . Am I correct in assuming that, even after September 1979, individual communities will be free to supplement accessible full-sized bus service with special services, to serve demands not met by the regular transit system, including the needs of the most severely handicapped individuals whose needs may not be able to be met by the regular transit system?
>
> Mr. WILLIAMS. That is correct . . . local officials . . . continue to retain the authority to supplement regular fixed-route service with specialized services on smaller, so-called paratransit vehicles in order to meet the needs of the elderly and the handicapped in a comprehensive way. . . .
>
> Mr. CHILES. I thank the Senator. I am particularly aware of the enormous differences which the section 16(b)(2) program has worked in the lives of elderly persons in diverse communities, and I wanted to be sure that this valuable assistance would continue to be available.[101]

HOUSE DECISION TO WAIT

The House, however, chose not to act on its counterpart to S. 208 (H.R. 5010), but to await the submission of a promised major reorganization of all highway and transit programs which the Carter administration proposed to offer in 1978. That plan was submitted to the Congress in February 1978 (S. 2440, S. 2441), and has a number of features which have the potential to improve transportation options for the elderly:

—The Federal share for highway construction *or* mass transit costs would be made a uniform 80 percent, ending the incentive for localities to choose road building over transit programs.

—Comprehensive planning requirements would be strengthened at both the State and local level.

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[99] Congressional Record, Jan. 26, 1977.
[100] Washington Post, Nov. 16, 1977; p. D15.
[101] Congressional Record, June 23, 1977.

—A new small urban and rural transportation program is proposed, with at least 10 percent of its funding reserved for public transit purposes. Also, for the first time, rural transportation programs would be eligible to receive Federal assistance for operating expenses.

Action on new transit legislation is likely in 1978, although the Carter proposal may undergo revisions. Its effects on current programs for the elderly must be clarified,[102] and questions have been raised about the adequacy of its funding levels. Senator Harrison Williams, chairing Senate Banking Committee hearings on S. 2441, had this appraisal:

> In general, the bill reflects the President's philosophy of simplifying Federal programs, increasing local flexibility and rationalizing sometimes fragmented and cumbersome administration. . . . For all of its implication and fine-tuning, the funding levels in S. 2441 are rock bottom. They will not allow for any program growth and expansion. . . . It is a barebones request that simply does not provide adequate funding. . . . it would not increase operating assistance to major, transit-dependent cities. At this critical point in the development of national transportation policy, these financial constraints will impede seriously the effort at all levels of government to reclaim and revitalize our urban areas, to promote public transportation as a realistic alternative to the private automobile in order to reduce our energy extravagance, and to provide mobility for our elderly and handicapped population.[103]

Senate Hearings on No-Fault Insurance.—The Senate Commerce Committee held 4 days of hearings on S. 1381, a bill to set minimal standards for State no-fault motor vehicle insurance laws, in July. Proponents of this legislation contend that it will result in less costly and more convenient auto insurance for older drivers. For example, a representative of the National Retired Teachers Association/American Association of Retired Persons testified:

> . . . a Federal minimum standards bill . . . would benefit the senior citizens of the United States. . . .
>
> There are several reasons, Senator, why that is true. One is that when older people are injured in automobile accidents, they are injured more seriously, and the injury lasts longer and they stay in the hospital longer.
>
> Second, they have a more immediate need for payment. They have fixed incomes. They are not able to expend large amounts on attorneys' fees, and they need, particularly, to have rehabilitative action start right away, quickly.
>
> Third, they need prompt payment. We understand that in Michigan now there is a period of 30 days compared with an average of 16 months under tort liability. And in many cases, those tort liability cases stretch as much as 5 years.

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[102] On Feb. 15, 1978, Committee on Aging Chairman Frank Church and ranking minority member Pete Domenici wrote to Secretary Adams seeking such clarification. This letter is reprinted in supplement 1, item 3, p. 267.

[103] Opening statement of Senator Harrison A. Williams, Jr., at hearings of Senate Banking, Housing and Urban Affairs Committee on Carter administration's transportation proposals, Mar. 1, 1978.

> In the fourth place, there is another factor which is important, which is the fact that persons injured in one-car accidents and injured pedestrians are compensated. Many older people are injured in situations of that kind, either single-car accidents or as pedestrians. . . .
>
> One other thing that we think is important, and that is, if benefits are coordinated and if insurance is coordinated, that lower premiums should result or that premiums should be held down.
>
> In other words, if the senior citizen can take account of other insurance which he owns, either health or accident insurance, he should have a lower premium on the no-fault insurance which he must buy.[104]

The Commerce Committee is expected to meet in April 1978 to consider reporting this legislation to the full Senate, following their receipt and review of a financial study of the no-fault programs operating in Michigan and California.[105]

Some States are exploring other changes in insurance practices which will promote equity for older drivers. Massachusetts, for example, is considering establishing new driver classifications based on individual driving records, and banning the use of age and other such factors as a determinant of a driver's premium charges.[106] (For additional discussion of insurance issues, see section C.)

New Local Initiatives.—Committee on Aging staff visited, in 1977, a number of locations where innovative solutions to the problem of adequate transportation for the elderly and handicapped are being tested.[107] These efforts include:

—St. Louis, Mo., is now operating the largest accessible bus fleet in the Nation. It consists of 157 lift-equipped buses, providing wheelchair accessibility, and 400 "kneeling" buses which ease entry and exit for persons with impaired mobility. The city transit agency is also extending technical assistance to local special transit providers, and eventually will provide coordination for all such services within the metropolitan region.

—Marin County, Calif., is developing a transit system combining full-size bus trunk lines, small bus feeder lines, and social service agency transit programs, in a coordinated and efficient manner specifically recognizing the needs of older residents. This system will tie in with similar efforts throughout the nine-county San Francisco Bay area, much of which is served by the full-access BART rail system.

—Portland, Oreg., is testing the feasibility of a radio-dispatched small bus system serving all city social service agencies and billing them, automatically, for the rides provided to their clients. Portland's Area Agency on Aging was the first to contract for this new service, and reports that it has provided more reliable service, at lower cost, while freeing agency personnel for the tasks of providing better assistance to the city's elderly.

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[104] Hearings before the Senate Committee on Commerce, Science, and Transportation on S. 1381; serial No. 95–44; pp. 190–91.
[105] Washington Post, Mar. 8, 1978, p. A4.
[106] Wall Street Journal; Oct. 11, 1977, p. 1.
[107] A committee staff analysis describing these projects in great detail is in preparation.

C. Continuing Problems

Despite these many positive developments, problems persist in the effort to provide better transportation for older Americans. The most significant are:

Insurance problems for special transit programs.—Committee on Aging Chairman Church convened a hearing on this subject, brought to his attention by the Idaho Office on Aging. In his opening remarks, Senator Church recounted some of the facts which initial inquiry had revealed: [108]

> I was startled when I heard that insurance premiums for coverage have gone up in some cases by hundreds of dollars—in one case more than $1,000—per vehicle. In some cases, insurance companies are denying coverage because drivers are 65 years or older, even though their safety records are better than those of younger drivers.
>
> I asked for examples of similar problems outside of Idaho, and they have not been slow in coming. Here are a few dollars-and-cents examples of what has aroused my concern:
>
> The Southwest Iowa Community Action Organization lost its policy after a single accident. They were not able to obtain new coverage until they agreed to fire every one of their drivers, all of whom were over 65.
>
> One witness today, from Virginia, has reported that the sharp increase in insurance rates is costing his nutrition programs 2,000 meals a year.
>
> Volunteer drivers had, until recently, been covered for supplementary personal liability under a low-cost plan offered by the Volunteer Insurance Service. But the underwriter of that program, the Hartford Insurance Co., has just withdrawn. Unless a substitute underwriter is located, all of the transportation provided by volunteers throughout the Nation may be jeopardized.
>
> The Western Idaho Commission on Aging has had its premium raised over $14,000 for 13 vans in a single year. Not only that, the premium will be raised for any van which goes more than 50 miles to reach isolated rural persons.
>
> Those are a few of the grievances we have received. The National Association of State Units on Aging, individual area agencies on aging, and the U.S. Administration on Aging are providing other examples.

The hearings revealed that many agencies were experiencing these problems despite excellent safety records. Individual States have the prime responsibility for regulating the insurance industry within their borders. However, actions have been taken as a result of the hearings:

—Committee staff are engaged in consultations with DOT officials, academicians, and insurance industry representatives in an effort to publicize the seriousness of the problem and to develop better statistical information as the basis for rate-setting.

—A committee questionnaire, distributed through the National Association of Area Agencies on Aging to all parts of the Nation, is undergoing analysis by the Senate Computer Center. It will

[108] "Transportation and the Elderly: Problems and Progress," pt. 6, "The Insurance Issue," July 12, 1977, p. 400.

yield information on the extent of these problems, and their effect on aging programs.

—The committee is also gathering data on efforts being undertaken by several States to purchase special transit insurance on a consortium basis and thereby qualify for discount "fleet rates."

Fragmentation and Duplication.—Committee on Aging hearings in prior years had shown that, in many communities, federally assisted paratransit services often operated in an uncoordinated and duplicative manner.

In October 1977, the GAO released a report confirming that this situation exists.[109] GAO recommended stronger actions by both Congress and the Office of Management and Budget to endorse and enforce coordination of resources.

President Carter's transportation proposals place great emphasis on State and local planning, and could help cope with this problem. In addition, HEW's Office of Human Development Services (OHDS) announced the funding of five demonstration projects which will test new concepts designed to promote improved coordination of such resources.[110] A total of $420,000 will back the first year of this 2-year program designed to demonstrate that the quality and amount of special transportation services can be improved through the coordination of existing resources. The projects, all of which will serve elderly individuals, will also test new organizational systems and seek to identify current barriers to coordination. OHDS presently spends $150 million annually for transportation services under 12 separate funding authorizations.

Rural Needs.—Committee on Aging field hearings in 1977 revealed that inadequate transportation is one of the most severe difficulties facing rural elderly residents (see chapter VI for further information). Again, the President's transportation initiative—by establishing a reserve within the small urban and rural grant program for rural public transportation, and by permitting operating expenses to be federally subsidized—is intended to address and alleviate such difficulties.

FINDINGS AND RECOMMENDATIONS

Several significant and positive developments in transportation for the elderly took place in 1977. Chief among these was Secretary Adams' decision to mandate accessibility on all buses purchased with Federal assistance. In addition, older Americans should soon have the opportunity to fly at lower fares.

However, problems persist. Special transportation services are threatened in some areas by escalating insurance premiums. And federally assisted paratransit services are often duplicative and noncoordinated.

The Committee on Aging is pursuing solutions to the insurance problem. In addition, the Congress should, while considering new transit legislation in 1978:

—Assure adequate funding levels, particularly for operating costs;

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[109] "Hindrances to Coordinating Transportation of People Participating in Federally Funded Grant Programs": report of the Comptroller General of the United States to the Senate Committee on Environment and Public Works, CED-77-119; Oct. 17, 1977.

[110] AoA-IM-78-4; Nov. 7, 1977. The projects are located in Fayetteville, Ark.; Howard County, Md.; White Plains, N.Y.; Grand Rapids, Mich.; and Jacksonville, Fla.

—Place increased emphasis on the development of rural transportation services;
—Design State and local planning requirements to eliminate fragmented and duplicative special transit services to the greatest practicable extent.

XII. "TAX FORMS AND TAX EQUITY FOR OLDER AMERICANS"

Most older Americans do not worry about income tax preparation because their incomes are below the Federal filing requirements.[111]

But a surprisingly large number must file a return. Information obtained from the Internal Revenue Service in 1977 revealed that almost 7.4 million returns were filed by elderly taxpayers in 1974—or 9 percent of the total. All in all, nearly 9.6 million persons 65 or older filed a Federal income tax return in 1974.

Facts about elderly's income taxes

	Taxable year 1974
Total returns filed	83, 340, 000
Total returns filed by persons 65+	7, 371, 124
Joint returns filed with one spouse 65+:	
Husband 65+	1, 803, 967
Wife 65+	305, 233
Returns filed by individual taxpayers 65+	3, 051, 275
Joint returns filed with both spouses 65+	2, 210, 649
Total taxpayers 65+	9, 581, 773
Returns with a retirement income credit (65+)	659, 000
Amount	$92, 788, 000
All returns with a retirement income credit [1]	813, 000
Amount	$124, 307, 000
Returns for taxpayers 65+ with taxable income	5, 469, 837
Amount of TI	$44, 248, 081, 000
Number of returns for taxpayers 65+ with tax due at time of filing	2, 970, 000
Amount	$2, 600, 000, 000
Overpayments for returns for taxpayers 65+	3, 415, 000
Amount	$1, 575, 000, 000
Number of returns asking for refund	2, 900, 000
Amount	$980, 000, 000
Returns for taxpayers 65+ claiming deduction for: [2]	
Gasoline tax	1, 650, 000
Amount	$138, 000, 000
Real estate tax	1, 700, 000
Amount	$1, 550, 000, 000
State and local sales tax	1, 900, 000
Amount	$480, 000, 000
Personal property tax	800, 000
Amount	$91, 000, 000
State and local income taxes	1, 400, 000
Amount	$1, 450, 000, 000

Footnotes at end of article.

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[111] See table below:

Filing status	*Required to file a tax return if gross income is at least—*
Single (under age 65)	$2, 950
Single (age 65 or older)	3, 700
Qualifying widow(er) under 65 with dependent child	3, 950
Qualifying widow(er) 65 or older with dependent child	4, 700
Married couple (both spouses under 65) filing jointly	4, 700
Married couple (1 spouse 65 or older) filing jointly	5, 450
Married couple (both spouses 65 or older) filing jointly	6, 200
Married filing separately	750

Facts about elderly's income taxes—Continued
Return for taxpayers 65+—Continued

Medical and dental expenses	2, 000, 000
Amount	$2, 800, 000, 000
Home mortgage interest	570, 000
Amount	$500, 000, 000

[1] Public pensioners under 65 years old could qualify for the retirement income credit if they met certain requirements.
[2] Estimates.

Source: Internal Revenue Service.

A. Thresholds for Elderly Taxpayers to Pay Federal Income Tax

Congress has enacted several measures to provide tax relief for older Americans, including: the additional personal exemption because of age,[112] an additional $35 general tax credit for taxpayers 65 or older,[113] the tax credit for the elderly,[114] and others.

These measures, combined with other general tax relief provisions for all age groups, makes it possible for an elderly single person to have $6,400 in pension income (other than social security) in taxable year 1977 and not be subject to Federal income tax. Persons receiving social security benefits (which are exempt from Federal income tax) and taxable income (e.g., pensions, interest, or rents) could have almost $9,300 in income—$4,200 [115] in taxable income and nearly $5,100 (the maximum benefit payable for a single worker retiring in 1977 at age 65) and not be subject to Federal income tax.

An elderly couple could have $10,450 in taxable pensions (or other taxable income) before being subject to Federal income tax. If a 65-year-old couple received maximum social security benefits (approximately $7,650 in 1977) based on the husband's earnings record, they could have an additional $7,200 in taxable income (pensions, interest, dividends, and other income)—or almost $14,850 in all—before being subject to Federal income tax.

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[112] Besides the regular $750 exemption allowed a taxpayer, a husband and wife who are 65 or older on the last day of the taxable year are each entitled to an additional exemption of $750 because of age

[113] The general tax credit also takes into consideration the exemptions for age and blindness.

[114] Under the tax credit for the elderly, an individual is allowed to subtract 15 percent of a maximum base figure from taxes owed for a given tax year. However, the maximum base figure is reduced by certain amounts of income. An individual's base figure is determined in the following manner:

(a) Individuals 65 and over are allowed to take into account for purposes of computing the maximum base figure up to $2,500 of adjusted gross income ($3,750 for couples filing jointly). This figure, however, is reduced by (1) Social security and/or railroad retirement annuities, and (2) $1 for every $2 in adjusted gross income over $7,500 ($10,000 for couples filing jointly).

(b) Individuals under 65 who receive public pensions are allowed to take into account up to $2,500 of retirement income ($3,750 for couples filing joint returns). This figure is reduced by (1) Social security and/or railroad retirement annuities, and (2) $1 for every $2 of earnings over $1,200 and up to $1,700, and dollar-for-dollar over $1,700. The amount for computing the credit is reduced dollar-for-dollar for earnings in excess of $900 for public pensioners under 62 years old.

Only persons 65 and older with adjusted gross incomes under $7,500 and no social security income are eligible for the full $375 credit. Those persons with modest incomes ($7,500–$12,500) receive little or no credit, while those with incomes above $12,500 receive nothing.

For persons under 65, there is an earnings test instead of the adjusted gross income phase-out rule, although the social security offset still applies.

The new tax credit for the elderly makes all income eligible for the 15 percent credit for persons 65 or older. Under the pre-1976 rules, only those receiving certain types of qualifying retirement income (pensions, annuities, rents, interest, and dividends) were eligible. The primary beneficiaries of this policy shift were elderly persons, whose social security was below the $2,500/$3,750 maximum base figure and whose adjusted gross income fell below the $7,500/$10,000 phaseout level.

[115] The tax-free amount of pensions and other taxable income is reduced from $6,400 to $4,200 because social security benefits of $2,500 a year or more have the effect of eliminating the tax credit for the elderly. The maximum amounts ($2,500 for a single aged person and $3,750 for an elderly couple) for computing the tax credit for the elderly are reduced dollar-for-dollar by social security benefits.

B. Key Administration Tax Proposals Affecting Older Americans

President Carter submitted his tax package to the Congress on January 23, proposing to reduce individual income tax liabilities by $23.5 billion in 1979 by authorizing a flat $240 personal credit and lowering the tax rates by 2 percent. In addition, the Administration called for the elimination of $5.8 billion in itemized deductions to simplify tax preparation by enabling more taxpayers to claim the standard deduction. Major items affecting elderly taxpayers include:

Rate reductions.—Tax rates would be reduced from the present range of 14 to 70 percent to 12 to 68 percent (effective October 1, 1978).

Personal credit.—The existing $750 personal exemption and the general tax credit (either $35 per exemption or 2 percent of the first $9,000 of taxable income, whichever is greater) would be replaced by a $240 tax credit for each personal exemption (effective October 1, 1978).

Medical expenses and casualty losses.—Medical care expenses and casualty and theft losses would be deductible only to the extent that, in the aggregate, they exceed 10 percent of adjusted gross income. A casualty or theft loss would be taken into account only to the extent it exceeds $100. Medical insurance premiums and medicines would be treated in the same manner as other medical expenditures (e.g., doctor or dental bills). Under present law, medical and dental expenses (unreimbursed by insurance or otherwise) are deductible to the extent that they exceed 3 percent of a taxpayer's adjusted gross income. Drugs and medicines are included in medical expenses (subject to the 3-percent rule) but only to the extent that they exceed 1 percent of adjusted gross income. However, one-half of medical, hospital, or health insurance premiums are deductible now (up to $150) without regard to the 3-percent limitation for other medical expenses. The remaining premiums can be deducted, but are subject to the 3-percent rule.

Nondeductibility of certain taxes.—State and local sales taxes, gasoline taxes, and personal property taxes not related to business activity would no longer be deductible.

Repeal of telephone excise tax.—The telephone excise tax (now 4 percent) would be repealed October 1, 1978, instead of being phased out by one percentage point per year until it is eliminated entirely on January 1, 1982.

The Administration estimates that these changes would increase the tax-free levels of income for individual taxpayers 65 or older by $850, from $6,400 to $7,250. In the case of an aged couple, the tax-free income levels would be boosted by $1,200—from $10,450 to $11,650.

TABLE 1.—COMPARISON OF TAX LIABILITIES FOR PERSONS AGED 65 OR OVER UNDER CURRENT LAW AND UNDER THE ADMINISTRATION PROPOSALS—1976 INCOME LEVELS

Expanded income class [1] (thousands of dollars)	Current law		Administration proposal		Difference	
	Number of taxable returns (thousands)	Amount of tax (millions of dollars)	Number of taxable returns (thousands)	Amount of tax (millions of dollars)	Number of taxable returns (thousands)	Amount of tax (millions of dollars)
Under 5	378	10	(2)	−13	−378	−23
5 to 10	1,651	589	985	291	−666	−298
10 to 15	1,083	1,113	1,035	888	−48	−226
15 to 20	541	1,039	538	910	−3	−129
20 to 30	501	1,739	501	1,561	----------	−179
30 to 50	305	2,109	305	1,980	----------	−129
50 to 100	158	2,709	158	2,654	----------	−56
100 to 200	51	2,016	51	2,044	----------	28
200 and over	15	2,192	15	2,279	----------	87
Total	4,682	13,518	3,588	12,593	−1,095	−925

[1] Expanded income does not include social security and railroad retirement benefits.
[2] Less than 500.

Note: All tax amounts include the full amount of the earned-income credit. Details may not add to totals because of rounding.

Source: Office of the Secretary of the Treasury, Office of Tax Analysis, Feb. 24, 1978.

C. "Tax Forms and Tax Equity" Hearing

Preparation of a tax return can be complicated, regardless of a person's age. But the task is frequently more complex for older Americans because they may be subject to a new set of rules upon reaching age 65. They may need to determine the excludable portion of the gain on the sale of a personal residence [116] or the taxable amount of a

[116] An individual can exclude from gross income part, or, under certain circumstances, all of the gain from the sale of his personal residence provided: (1) The taxpayer was 65 or older before the date of the sale: (2) The taxpayer owned and used the property as a principal residence for a period totaling at least 5 years within the 8-year period ending on the date of the sale, and (3) The taxpayer has not elected this exclusion at any time in the past.

Taxpayers meeting these requirements can exclude their entire gain if the adjusted sales price (see definition below) of their residence is $35,000 or less. If the adjusted sales price exceeds $35,000, taxpayers can exclude part of the gain based on a ratio of $35,000 over the adjusted sale price of the residence.

To begin this computation, the taxpayer subtracts selling expenses (e.g., commissions in connection with the sale, advertising expenses, or legal fees) from the selling price of the residence. This gives the taxpayer the amount realized from the sale. The adjusted basis of the residence (i.e., the cost plus any capital improvements less any casualty loss or depreciation is subtracted from the amount realized, producing the total gain realized.

Then the taxpayer must determine the adjusted sales price—the amount realized minus any fix-up expenses. To qualify as fix-up expenses, they must:

(1) Be for work performed during the 90-day period ending on the day the contract to sell was made;
(2) Be paid within 30 days after the date of the sale;
(3) Be otherwise nondeductible in computing taxable income; and
(4) Not be capital expenditures or improvements.

If the adjusted sales price exceeds $35,000, the gain which may be excluded from gross income is determined by multiplying the total gain realized by $35,000 over the adjusted sales price. This amount is then subtracted from the total gain realized and produces the amount which the taxpayer may not elect to exclude from gross income.

Example.—Mr. James sold his principal residence for $44,000 when he was 76. He is eligible and does elect to exclude from his gross income for his tax year the gain attributable to $35,000 of the adjusted sales price of his old residence. His selling price, selling expenses, fixing-up expenses, etc., are shown in the following computations:

Total gain realized:	
1. Selling price of old residence	$44,000
2. Less: Selling expenses	3,500
3. Amount realized	40,500
4. Less: Adjusted basis of old residence	32,500
5. Total gain realized	8,000
Adjusted sales price:	
6. Amount realized (item 3)	40,500
7. Less fixing-up expenses	500
8. Adjusted sales price	40,000
Gain attributable to $35,000 of adjusted sales price, Mr. James elects to exclude:	
9. Total gain realized (item 5)	8,000
10. Less: Gain taxpayer elects to exclude from gross income 35,000/40,000 × $8,000	7,000
11. Gain that taxpayer may NOT elect to EXCLUDE from gross income	1,000

pension.[117] These computations can be difficult, even for experienced tax preparers.

This point was emphasized during a hearing held by the Committee on Aging on "Tax Equity and Tax Forms for Older Americans." [118]

Senator Church said:

> Unfortunately, some of these tax benefits require a maze of computations, statements, and schedule tranfers to complete.
>
> For the unsuspecting taxpayer, form 1040 with its accompanying schedules can be like going through a minefield with numerous linguistic boobytraps.
>
> My point is this: tax relief provisions are not very helpful unless they are workable and understandable.[119]

The hearing examined other important issues, including the tax credit for the elderly, the effect of the administration's tax package upon the aged, and the need for tax counseling assistance.

1. TAX CREDIT FOR THE ELDERLY

Senator Church laid the groundwork for discussion of the tax credit for the elderly when he said:

> . . . Some elderly taxpayers are discovering that they are being penalized upon reaching age 65.
>
> Qualifying persons under 65 years of age may now claim a 15-percent credit on up to $2,500 of government pensions, producing a $375 tax savings for persons with no social security benefits and little earnings.
>
> But upon becoming 65, these individuals may lose the credit entirely, even though their needs may be greater. This is because the $2,500 starting point is reduced by $1 for each $2 of adjusted gross income above $7,500. The effect is that the credit is phased out completely for persons with income of $12,500 or more.[120]

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[117] As a general rule, the taxable portion of an anuity involves a three-step process. First, the taxpayer must determine his exclusion percentage, which is computed by dividing the expected return into the investment, which is the amount of premiums paid. If the taxpayer has a fixed-period annuity, his expected return is computed by multiplying the fixed number of years or months for which payments are to be made by the amount of the payment specified for each such period. In the case of an annuity for life, the expected return is determined by multiplying the amount of annual payment by a multiple (from the annuity tables) that is based on the taxpayer's life expectancy as of the annuity starting date.

Second, an individual would multiply the annual annuity income by the exclusion percentage, which would equal the pro rata return on the investment not included in income.

A special rule exists in instances where the annuitant will recover the investment within 3 years after receiving the first payment. In this case, the periodic amounts received are not taxable until the entire cost is recovered. Once the investment is recovered, the entire excess amount received is taxable.

Example.—Jack's annuity, with a net investment of $9,000, pays him $1,000 a year for life. The multiple he uses is 15.0 as shown in the Internal Revenue Service actuarial table for his age (male age 65), and his expected return is $15,000 (15 x $1,000). His investment of $9,000 divided by his expected return of $15,000 equals 60 percent, the percentage he will exclude. Each year Jack will exclude $600 (60 percent of $1,000) and consider $400 as income, as long as payments are received.

Three-year-rule example.—Evelyn Jones retired on Jan. 31, 1979, with a monthly pension of $200. Her pension cost was $4,925. During the first 3 years she will receive $7,200, which is more than her total cost. In 1975 Evelyn drew $2,200 ($200 x 11), which was tax-free. In 1976 she received $2,400 which also was tax-free. However, in 1977, she is required to report $2,075 as income, computed as follows:

Total pension received in 1977	$2,400
Cost: Her total contributions	4,925
Less: Cost received tax free in 1976 and 1975 ($2,200 plus $2,400)	4,600
Unrecovered cost	325
Amount of pension reportable as income in 1977	2,075

[118] "Tax Forms and Tax Equity for Older Americans," U.S. Senate Special Committee on Aging, Feb. 24, 1978, hearing not yet in print.

[119] Opening statement at hearing cited in footnote 118.

[120] Opening statement at hearing cited in footnote 118.

This led to intense analysis of proposals (H.R. 8818 and S. 2128) to (1) eliminate the adjusted gross income phase-out provision entirely for the tax credit for the elderly, (2) raise the maximum amounts for computing the credit from $2,500 to $3,000 for aged individuals and from $3,750 to $4,500 for elderly couples, and (3) provide cost-of-living adjustments for the credit.

Mr. Emil Sunley, Deputy Assistant Secretary for Tax Policy of the Department of the Treasury, opposed these measures on the following grounds:

—The first-year cost would be $963 million;

—Substantial relief would accrue to the relatively affluent elderly. Approximately one-fourth of the benefits would go to aged taxpayers with incomes exceeding $30,000. Taxpayers with $50,000 or more of income would have their taxes reduced by $100 million.

However, Stephen Skardon, legislative assistant for the National Association of Retired Federal Employees, stressed that the proposed changes are needed because:

(1) The tax credit for the elderly is inadequate and fails to accomplish its purpose.

(2) All persons 65 or older will be eligible for either the tax exemption under social security or a tax credit.

(3) The elimination of the phase-out rule would remove what is, in essence, a penalty against savings and investment income, and active employment earnings by persons 65 or older.

2. ADMINISTRATION'S TAX PACKAGE

James Hacking, assistant legislative counsel for the National Retired Teachers Association/American Association of Retired Persons, supported the administration's proposed tax rate reduction. He opposed, though, the recommendations to eliminate the sales tax and personal property tax deductions, as well as substituting a single hardship loss for the existing medical expense and casualty loss deductions.

He also emphasized the need to reduce the social security tax increase enacted into law in December 1977, giving this rationale:

> We are seriously concerned about the consequences of a policy of increasing social insurance payroll taxes on the one hand and cutting income taxes on the other. First, such policy will increase the share of Federal Government revenue derived from regressive payroll taxes relative to that derived from progressive income taxes. Second, at a time when continued reduction in unemployment is a primary economic goal, it makes no sense to discriminate against labor by enacting legislation that schedules enormous increases in payroll taxes. Higher payroll taxes increase the cost of labor (relative to the cost of capital) and make reducing employment that much more difficult. Third, many households will lose more from payroll tax increases than they will gain from income tax cuts; households not subject to the payroll tax increases will gain a windfall via the income tax cuts.[121]

[121] Testimony at hearing cited in footnote 118.

3. INCOME TAX ASSISTANCE

The Internal Revenue Service has emphasized repeatedly that the Federal Government wants no individual to pay more taxes than are legally due.

Under the volunteer income tax assistance program, the Internal Revenue Service trains volunteer tax consultants to assist taxpayers in preparing their returns. VITA does not have an income test as such. However, the program is designed to provide assistance to individuals who might otherwise have difficulty in paying a fee for a professional tax consultant. For example, VITA programs are typically located in low- or middle-income areas. The VITA programs consist of three major activities:

(1) Training volunteer tax consultants.

(2) Promotional work (e.g., IRS may conduct a seminar or conference at a law school, PTA, senior center, school, or elsewhere to encourage persons to participate in VITA).

(3) Prepare and distribute helpful tax publications (e.g., "Tax Benefits for Older Americans").

Volunteers do actual tax preparation and answer questions. Present volunteers undertake a 2-day training session to keep abreast of developments in the tax law. New volunteers receive 3 days of training.

Facts about VITA	Fiscal 1978	Fiscal 1979 budget
Funding	$800,000	$800,000
Funding for elderly tax counseling assistance	[1] $320,000	[1] $324,000
Volunteers trained	[1] 25,000	[1] 30,000
Elderly volunteers trained	[1] 10,000	[1] 12,000
Number of VITA returns	[1] 240,000	[1] 285,000
Number of elderly VITA returns	[1] 105,000	[1] 120,0000
Cost per volunteer	[1] $32	[1] $27
IRS staff years invested	50	50

[1] Estimates.

4. ADDITIONAL HELP PROPOSED

At the hearing, NRTA–AARP, urged that the Congress provide increased funding for VITA. In addition, NRTA–AARP recommended that the Older Americans Tax Counseling Assistance Act (S. 835) be enacted into law.

S. 835 would authorize the IRS to enter into training and technical assistance agreements with nonprofit agencies to prepare volunteers to provide tax counseling assistance for elderly persons (at least 60 years old at the end of the taxable year). The bill would permit volunteer tax counselors to be reimbursed for their out-of-pocket expenses in assisting taxpayers. S. 835 would also authorize the IRS to conduct special alerts to make elderly persons aware of helpful tax relief provisions, such as the total or partial exclusion (for taxpayers 65 or older) on the sale of a personal residence or the tax credit for the elderly.

5. IMPROVING TAX FORM AND INFORMATION SERVICE

David Marlin, director for the Legal Research and Services for the Elderly program, offered several suggestions to make tax information more understandable and available for older Americans:

—IRS should distribute to State and local offices on aging and senior citizen organizations brochures summarizing tax benefit provisions for the aged.
—IRS should "circuit ride" during the tax season through towns and counties not having permanent IRS offices.
—The IRS WATS line number should be publicized in local newspapers and television and radio stations.
—The type face for the form 1040 instructions should be enlarged.

FINDINGS AND RECOMMENDATIONS

Some progress has been made in recent years in simplifying tax preparation. But millions of Americans may feel as if they are trapped in a maze of complex computations and schedule transfers. This is especially true for older Americans, who frequently discover that the tax rules change and become more complex upon reaching retirement age or 65.

More than 100,000 elderly persons are expected to receive tax preparation and tax counseling assistance under the VITA program in 1978. The need, though, is much greater.

For these reasons, the committee urges that tax counseling assistance be expanded by (1) increasing funding for VITA and (2) prompt enactment of an Older Americans Tax Counseling Assistance Act.

The committee further urges that the Congress pass legislation to improve the tax credit for the elderly and to protect aged taxpayers from being penalized upon reaching age 65.

XIII. EDUCATION AND AGING

Steps toward gearing up the Office of Lifelong Learning—established by the Higher Education Amendments of 1976 (Public Law 4–482)—took place in 1977, with prospects good for accelerated action in 1978.

The 1976 amendments gave the Office of Lifelong Learning the responsibility to analyze and coordinate all existing programs serving learners of all ages, develop a report, and make recommendations to the Congress.

Now nearing completion, the report will include information on training opportunities and volunteer efforts as well as actual educational programs.

One working paper [122] already submitted for reference in the final report sums up present Federal efforts to provide educational opportunity in middle and later years. One problem intensifying all others is the paucity of information on the number of older persons actually served:

> . . . the majority of Federal programs supporting lifelong learning activities do not maintain statistics identifying their participants by age. There were more than 270 Federal programs providing lifelong learning (for all age groups) in fiscal year 1976, dispersed throughout 29 cabinet

[122] "The Older Adult and Federal Programs For Lifelong Learning," Pamela Christoffell, The College Board, Washington, D.C., December 1977.

level departments and agencies, and few can tell how many older adults they are serving.

The author, relying on estimates, gave this description of the total Federal effort:

> Looking over the total Federal lifelong learning effort for older adults, it is possible to identify at least 50 Federal programs which provide some education or training activities in which older adults participate. But this number is misleading. The activities are fragmented, relatively narrow in scope, and probably represent funding levels of less than 1 percent of the over $14 billion the Federal Government spent on education and training for all persons past compulsory school age in fiscal year 1976. The bulk of the Federal effort appears to be concentrated in just a few of these programs, such as cooperative extension (Agriculture), the adult and vocational education programs (Office of Education), aging programs and Rehabilitation Services (Office of Human Development), comprehensive employment and training programs (Labor), and civil service training.

A list of the majority of these lifelong programs, by administering agency and program name, follows:

FEDERAL LIFELONG LEARNING PROGRAMS ESTIMATED TO BE SERVING OLDER ADULTS, FISCAL YEAR 1976

OMB catalog No.[1]	Administering agency	Program name
10.500	Agriculture—Extension Service	Cooperative extension.
11.700	Commerce—National Fire Prevention and Control Administration.	"Public education project."
11.800	Commerce—Office of Minority Business Enterprise.	Minority business enterprise.
Programs not found in the catalog.	Defense	Education and training.
13.925	HEW—Assistant Secretary for Education Office	Fund for the improvement of postsecondary education.
13.403	HEW—Office of Education	Bilingual education.
13.539	do	Basic educational opportunity grants.
13.543	do	Educational opportunity centers.
13.454	do	Strengthening developing institutions.
13.491	do	University community services grants to States.
13.446	do	Handicapped media services and captioned films.
13.400	do	Adult education grants to States.
13.493	do	Vocational education basic grants to States.
13.494	do	Vocational education consumer and homemaking.
13.489	do	Teacher corps.
13.533	do	Right to read.
13.536	do	Adult Indian education.
13.561	do	Metric education.
13.563	do	Community education.
13.564	do	Consumer education.
13.464	do	Library services.
13.475	do	Library demonstration.
13.634	HEW—Office of Human Development	Administration on Aging, model projects.
13.637	do	Administration on Aging, training.
13.635	do	Administration on Aging, nutrition program.
13.600	do	Head Start.
13.624	do	Rehabilitation services and facilities basic support.
13.625	do	Vocational rehabilitation services for social security disability beneficiaries.
Program not found in the catalog.	HEW—Social Security Administration	Supplementary security income.
15.107	Interior—Bureau of Indian Affairs	Indian action team.
15.100	do	Indian education—Adults.
16.518	Justice—Law Enforcement Assistance Administration.	JJDP national institute.

See footnote at end of table.

FEDERAL LIFELONG LEARNING PROGRAMS ESTIMATED TO BE SERVING OLDER ADULTS, FISCAL YEAR 1976—Con.

OMB catalog No.[1]	Administering agency	Program name
16.504	do	Student financial aid.
16.513	do	Training.
17.400	Labor—Bureau of International Labor Affairs	Trade adjustment assistance workers.
17.230	Labor—Employment and Training Administration.	Migrant and seasonal farm workers.
17.232	do	Comprehensive employment and training programs.
17.234	do	Indian and Native American employment and training.
17.226	do	Work incentives program.
17.235	do	Senior community service employment program.
19.102	State—Bureau of Education and Cultural Affairs.	Education exchange—University lecturers and research scholars.
21.003	Treasury—Internal Revenue Service	Tax information and education.
72.001	ACTION	Foster grandparent program.
72.008	do	Senior companion program.
72.002	do	Retired senior volunteers.
	Civil Service Commission	Training for Federal employees.
45.—	National Foundation on the Arts and Humanities National Endowment for the Arts.	Various programs.
45.—	National Foundation, National Endowment for the Humanities.	Various programs.
64.111	Veterans' Administration	Veterans' educational assistance.

[1] Refers to the "Catalog of Federal Domestic Assistance."

The Office of Lifelong Learning, without funding since its establishment, will apparently soon have an operating budget. This year's budget request includes $5 million "to improve and expand lifelong learning opportunities." Grants will be available to State agencies, institutions of higher education, and public and private nonprofit organizations.

A. Other Developments

As reported in this committee's last annual report,[123] interest in learning related to aging is apparently on a steady upswing. Among the developments in 1977:

—The U.S. Office of Education and ACTION's older Americans volunteer programs signed an agreement on November 29 intended "to facilitate the delivery of reading assistance and instruction through the involvement of older American volunteers in reading and literacy programs across the country." [124]

—Additional progress in improving attention given to gerontology and geriatrics in the curricula of institutions of higher learning was reported: (1) The Association for Gerontology in Higher Education reported [125] that 60 of 65 responding institutions offered at least one course in gerontology and that 23,662 students attended these courses ranging in size from 3 to 300. Two schools, the University of Michigan and Syracuse University, had over 2,000 students each in gerontology courses; (2) the Ohio General Assembly, on August 16, enacted legislation (section 3333.111 of the revised code) requiring establishment of an office or department of geriatric medicine at schools or colleges of medicine in the State university system; (3) the National Institute of Medicine, at the request of the National Institute on Aging, is conducting a survey of the incorporation of knowledge about aging within medical education. A report is due on September 29, 1978.

[123] See pp. 169–71, "Education for Older Persons," in "Developments in Aging: 1976."
[124] U.S. Office of Education Press release, Nov. 25, 1977.
[125] In letter to Senate Committee on Aging, Feb. 10, 1978.

—The Kentucky Council on Higher Education, with funding of $75,000 from title XX of the Social Security Act and $25,000 authorized by Kentucky House Bill 466, has begun work on a higher education gerontology project called "Development of Gerontology Curricula in State-supported Colleges and Universities." "To our knowledge," says Associate Council director for General Programs Dale F. Chapman,[126] "this project represents the first time anyone has ever tried to coordinate and plan faculty development in gerontology by staging a faculty in-service training program, statewide analysis in course and degree of offerings, and a range of other activities . . ."

—Older persons continue to play a major role in the school volunteer program for the city of New York. The annual report for 1976–77 noted: "In 1976–77, 955 older adults between the ages of 50 and 85 performed tutorial services in 192 achools. About 50 percent of them were over the age of 65."

—The National Senior Citizens Education and Research Center announced in 1977 a reactivated effort to make adult and continuing education more available to older persons. The Center will also pay special attention to preretirement training and counseling, alternative health care systems, manpower programs, and leadership-advocacy training programs. The Center is affiliated with, but independent from, the National Council of Senior Citizens.

Directors of 100 senior centers met in June 1977 to discuss assisting in recruiting volunteers during the coming school year.

B. Community Education

During fiscal year 1978, $3.5 million was allocated for State and local community educational programs throughout the country. These funds are awarded to State and local educational agencies to establish and continue community education programs—programs which involve the entire community in the neighborhood schools and their activities. In the past, senior centers and elderly persons have often been involved in the community education programs in educational, social, and service programs. The wide scope of activities and services offered by the community schools has been of great assistance and interest to the elderly community.

Since 1974, community education has been a small program under the Elementary and Secondary Education Act and administered by the Office of Education (OE). In March of 1978, Senators Williams, Riegle, Magnuson, Chiles, Domenici, Kennedy, Hayakawa, Randolph, Hatfield, Hathaway, McGovern, DeConcini, Pell, and Church introduced legislation (S. 2711) which would expand community education into a complete new title X under ESEA. This title would support an expansive community program by increasing the number of grants available to State and local educational agencies. In addition, S. 2711 would urge the coordination of education and services programs, including the Older Americans Act. This would enable services to be available through and in coordination with the educational system offered by the community schools.

This legislation is expected to be acted upon this spring as a part of the overall ESEA extension legislation.

[126] In a letter to the Senate Committee on Aging, Mar. 16, 1978.

C. Arts and the Elderly

During the past year, the proceedings[127] from the first national conference on arts and aging sponsored by the National Council on the Aging's Center for Arts and Older Americans became available. It includes a directory of arts programs for older persons. The National Endowment for the Arts describes it as "a timely resource document for arts and aging organizations who wish to initiate similar efforts in their own communities."

Another source of information now available is the "Humanities Exchange," a newsletter issued from time to time by the NCOA's senior center humanities program.

In January 23, 1978, testimony before the House Subcommittee on Aging at a hearing on the 1979 White House Conference on the Arts Act (H.J. Res. 600), Jacqueline T. Sunderland, Director of the National Center on Arts and the Aging, said:

> . . . a major barrier to the aged's full participation in our society is the negative attitude toward aging held by so many. The arts let older people demonstrate their creativity and dynamism to the public and to themselves. It is one way that we can tear down the vicious stereotypes that allow us to put the aging on a shelf—out of sight and out of mind. Older people actively engaged in arts programs are letting younger people and their own peers know age isn't something to be feared but lived vigorously.

She also gave the following examples of actions taken by several arts and aging agencies and organizations to seek out a new or renewed constituency for the arts among older people:

—Recently, the American Theatre Association established a task force to institute a major new program division on senior adult theater that will eventually have the status of their other divisions such as the American College Theatre Festival.

—The Arts Council of Greater New Orleans and the Louisiana District I Area Agency on Aging, working together, are well along in their coordinated, jointly supported program to involve older persons in arts events and programs. Their experiences and expertise will be shared with our conference participants in Lexington and with many thousands more through the book of conference proceedings we will publish in the spring.

—Hospital Audiences, Inc. (HAI), in New York City, under a grant from the Administration on Aging/HEW, is placing professional artists and artist-teachers in institutional settings for the aged to help prove that quality arts experiences can humanize impersonal environments.

—The Mayor's Office for Senior Citizens in Chicago subcontracts to community arts groups (at $100,000) for arts programs and services to the urban elderly. This is a recent and substantial commitment.

Livingston Biddle, Chairman of the National Endowment for the Arts and Chairman of the National Council on the Arts, said, in a statement submitted to the House Subcommittee on Education in

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[127] "Arts and the Aging: An Agenda for Action." See reference to this report in part 2 of this report, statement by the National Endowment for the Arts.

March 1978, that the Endowment continues its partial support of the Center on Arts and the Aging to help the Center "stimulate a national awareness of the importance of including cultural activities as an integral part of social service programs supported by State and local agencies on aging.

He also said.

> Based on the Endowment's experience, we know that most older people have the desire and potential to be creative to experience new activities, to continue to "grow" as individuals.

D. Television and the Older Audience

"Over Easy," a daily half-hour television report funded largely through Older Americans Act demonstration funds,[128] reportedly was attracting widespread attention soon after it began regular shows last autumn. According to the project director, the program:

> . . . was being watched by 4 million viewers by the third week of broadcast. Since then, a Nielsen survey indicates that viewership has increased by 77 percent in 13 major markets. We are now confident that over 2 million persons are viewing "Over Easy" each day. The programs are carried on 254 Public Broadcasting stations, more stations than any other program on either public or commercial networks. The impact of "Over Easy" is demonstrated by the fact that over 12,000 viewers have felt compelled to write and thank us for our efforts on their behalf.[129]

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[128] The fiscal year 1978 Administration on Aging budget contained $3 million for media communication.
[129] In letter to Senate Committee on Aging Chairman Frank Church, Mar. 2, 1978.

CHAPTER XI

WORLDWIDE ATTENTION TO AGING

United Nations studies predict that the actual numbers and proportions of older populations will increase markedly within developed and developing nations during the next few decades.

Increasing awareness of the vast changes which will accompany the "Graying of Nations" led in 1977 to:

—Actions by both Houses of the U.S. Congress requesting the United States delegation to the United Nations to work toward a World Assembly and World Year on Aging in 1982.

—A U.N. vote on December 6 asking member nations to express their position on a World Year and World Assembly by this July.

—Establishment of a World Health Organization program in aging, including projects which will extend until 1980.

—Participation by the U.S. National Institute on Aging in meetings with directors of other institutes or other specialists from 11 nations.

—Congressional proposals for a U.S. White House Conference on Aging in 1981.

I. PERSPECTIVE FROM OTHER NATIONS

Visitors from abroad gave the U.S. Senate Committee on Aging, at a public roundtable discussion in November,[1] firsthand reports on research and other aging-related activities in 10 other nations.

Committee Chairman Frank Church cited U.S. statistics showing dramatic projected increases in population groups of age 60 and above (see accompanying tables). He also referred to a U.N. report which declared:

> It would appear from the demographic overall view of world population trends, as well as the critical conditions and potential resources found among aging populations throughout the world, that aging may be one of the crucial social policy questions of the latter third of the 20th Century.[2]

[1] "The Graying of Nations: Implications," Washington, D.C., Nov. 6, 1977, Senator Pete V. Domenici presiding.

[2] Page 3 of reference cited in footnote 1.

1970 POPULATION ESTIMATES AND PROJECTIONS FOR 1985 AND 2000 BY MAJOR REGIONS, WITH THE NUMBER OF THOSE 60 AND OVER

Region and year	Total population (thousands)	Population 60 yr and over	
		Number (thousands)	Percentage of total population
World total:			
1970	3,631,797	290,697	8.0
1985	4,933,463	406,750	8.2
2000	6,493,642	584,605	9.0
More developed regions:			
1970	1,090,297	153,741	14.1
1985	1,274,995	188,602	14.8
2000	1,453,528	231,105	15.9
Less developed regions:			
1970	2,541,501	137,024	5.4
1985	3,658,468	218,474	6.0
2000	5,040,114	353,917	7.0

Source: The demographic materials contained in this graph are based upon information obtained from the Population Division, Department of Economic and Social Affairs of the United Nations Secretariat. Projections for the years 1985 and 2000 are based upon the medium variant projections as defined by that Division.

1950–70 ESTIMATES OF PERCENTAGE INCREASE IN THE POPULATION AND PROJECTIONS FOR 1970–2000

Region and year span	Percentage increase of—		
	Total population	60+ population	70+ population
World total:			
1950 to 1970	46.1	54.7	56.0
1970 to 2000	78.8	101.1	118.7
More developed regions:			
1950 to 1970	27.1	59.3	65.5
1970 to 2000	33.3	50.3	70.0
Less developed regions:			
1950 to 1970	56.1	49.9	44.6
1970 to 2000	98.3	158.3	186.9

Source: The demographic materials contained in this graph are based upon information obtained from the Population Division, Department of Economic and Social Affairs of the United Nations Secretariat. Projections for the years 1985 and 2000 are based upon the medium variant projections as defined by that Division.

Senator Pete Domenici, ranking minority member of the committee, recognized the need to anticipate the changes occurring due to the "aging" of society. He added:

> The graying of nations is, in reality, a success story. Elimination of disease, increased longevity, and planned population growth have contributed to this shift. We are here today to discuss effective methods for coping with new realities brought about by our successes in other fields.[3]

[3] Page 2 of reference cited in footnote 1.

A. The Need for Information

U.S. National Institute on Aging Director Robert Butler [4] described a "demographic revolution" causing an urgent need to adapt to changing economic, social, and health realities:

> The capacity for making these adaptions depends upon greater understanding of the needs and problems of older people and a commitment to meeting these needs. Societies have made notable progress in providing for older people both through income maintenance and creation of service programs. However, perhaps our greatest lag has been in the area of fundamental research.
>
> Such research need not be seen as esoteric or impractical. New knowledge in biology, medicine, and the psychological and social sciences is directly transferable to human betterment. New knowledge on nutrient utilization will improve our social dining programs. New knowledge on geriatric pharmacology will enable physicians to prescribe the correct drug in the proper dosage. Similar examples of the practical applicability of results of fundamental research can be drawn from any field. In addition, information obtained from demographic and epidemiologic studies can help us to reorient our health care system so as to better meet the needs of the older population. The judicious coupling of fundamental and more applied research is the strategy with greatest potential for producing progress in health care and other kinds of service delivery systems.[5]

Butler said that international sharing of information and coordination of research efforts is "imperative." He added:

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[4] The NIA, along with the Fogarty International Center (a unit of the U.S. National Institutes of Health) and the World Health Organization, were hosts on Nov. 9–10, 1977, in Bethesda, Md., to the second meeting of directors of national institutes with programs in the field of aging. Participants in that meeting and in the Senate roundtable discussion included: Sir Ferguson Anderson, M.D., F.R.C.P., University of Glasgow, Scotland; Prof. Ana Aslan, Director, National Institute of Gerontology and Geriatrics, Bucharest, Romania; Prof. Dmitri F. Chebotarev, Director, Institute of Gerontology of the U.S.S.R. Academy of Medical Sciences, Kiev, U.S.S.R.; Dr. Hana Hermanova, Scientific Secretary, Third Medical Clinic, Prague, Czechoslovakia; Dr. Gudmund Harlem, medical director, Institute of Medical Rehabilitation, Oslo, Norway; Dr. Gustav Vig, chairman of the board, Norwegian Institute of Gerontology, Hamar, Norway; Prof. Francois Bourlière, INSERM Gerontology Research Unit, Paris, France; Prof. Carel F. Hollander, M.D., Ph. D., Director, Institute for Experimental Gerontology TNO, Rijswijk, the Netherlands; Dr. Kunio Oota, Director, Metropolitan Institute of Gerontology, Tokyo, Japan; Henning Friis, Executive Director, National Institute of Social Research, Copenhagen, Denmark; Prof. Alvar Svanborg, Head, Clinic II Basa Hospital, Gothenborg, Sweden; Dr. R. Glyn Thomas, European Office, World Health Organization; Dr. Milo Leavitt, Director, Fogarty International Center, U.S. Department of Health, Education, and Welfare.

[5] Page 13 of reference cited in footnote 1. Dr. Butler, in a speech before the National Conferen on County Resource Development for Aging Citizens in January 1977, made these additional comments: " w knowledge, fundamental understanding through research, I submit, is the ultimate service, and t. ultimate cost containment. Without new knowledge through research, we will just keep on doing the same .d things in the same old ways, at ever-increasing costs."

> Sharing resources is also of utmost importance to improved training of both research and health services manpower. For example, rapid training in geriatric medicine may be made by giving fellowships to study in countries with more fully developed systems of geriatric care and training.

Professor Dmitri Chebotarev of the U.S.S.R. said later:

> . . . we recognize that the gerontological problems have become so extensive that their solution can be made on an international level.[6]

A similar view was expressed by Dr. Kunio Oota of Japan:

> . . . I personally feel that our gerontological research cannot be efficiently performed unless the institute is open to, and collaborates closely with, neighboring scientific worlds, such as the biological, medical, and sociological colleges and institutes, both domestic and foreign. Every effort has been made along this line.[7]

The aging process: Dramatic breakthroughs to increase longevity were not foreseen by the expert witnesses. A different objective was described by Professor Carel F. Hollander of the Netherlands:

> Investigations into the biology of aging should not be aimed at increasing longevity, but should be aimed at increasing the quality of life in this phase of human existence by either delaying or shortening, or both, the process of aging associated with physical diseases or infirmities.[8]

Professor Francois Bourlière of France described differential rates of aging and added a comment related to an issue which is receiving intensive attention in the United States:

> There is, for instance, a 4-year difference in further expectation of life at 60 years of age between male schoolteachers, professionals, and executives on the one side, and male wage-earning farmworkers and unskilled town workers on the other side. The present policy of mandatory retirement at a same chronological age of very different occupational groups is therefore medically questionable, to say the least.

In response to a question from Senator John Glenn about the extent of research on causes and prevention of pain, Dr. Butler said that the NIA is collaborating actively with the National Cancer Institute on the treatment of pain in advanced illness.

B. Health Care Delivery and Geriatric Training

Increasing incidence of disability and dependence, particularly among persons 70 and over, appears to occur in all nations, but countries represented by several witnesses described a greater reliance upon in-home services and other noninstitutional care than in the United States.

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[6] Page 21 of reference cited in footnote 1.
[7] Page 32 of reference cited in footnote 1.
[8] Page 30 of reference cited in footnote 1.

Sir Ferguson Anderson, described by Dr. Butler as "a world-renowned pioneer in the field of geriatric medicine," discussed the range of options open in Glasgow, Scotland:

> The general practitioner, seeing a very ill old person, has the opportunity of deciding whether to send that patient to intensive care or to the geriatric unit in the local hospital. He, as a result of experience, decides which services he requires but beds are available for old people, especially set aside for them. He may on the other hand, refer his elderly patient to the geriatric outpatient department or to a geriatric day hospital. Lastly, he may ask the consultant physician in geriatric medicine to see the ill old person in her own home. The third and most important aspect of this has been the creation of the health care team. Here, the general practitioner has to assist him a community nurse—the district nurse—a health education nurse, whom we call the health visiting nurse, and the advice of a social worker. Extensive domiciliary services are available to help the elderly person in his own home ranging from the home nurse, domestic help, laundering for the incontinent patient, alteration to housing, meals-on-wheels, domiciliary physiotherapy, occupational therapy, chiropody, or, on occasion, dentistry. *I would stress that the basis of the service is the home care of the patient.*" [9] [Emphasis added.]

The hospital beds reserved for the elderly were described by Sir Ferguson as part of a "dynamic and active" process in which return to the community, where feasible, is considerably accelerated. He added:

> The length of stay of patients in such admitting units has decreased so that more patients are passed through the same number of beds.

Professor Ana Aslan of Romania said that 123 medical-social centers of prevention "all over the country" are helping to prevent institutionalization.[10] Dr. Hana Hermanova of Czechoslovakia described the functions of geriatric nurses in that nation:

> Prevention is a very important duty. . . . She visits aged people living alone, even if they are not registered at the primary care physician, and she follows their physical and mental state, mobility, ability to cope with activities of daily living, nutrition, and personal and environmental hygiene. She reports to the hygienic service and to the primary care physician. In case of need she arranges for domestic help or placement in an institute. She is a partner of the hospital social worker when the elderly are discharged.[11]

In Norway, said Dr. Gustav Vig, all communities have home help and home nursing, receiving a 75 percent refund from the State for home nursing and 50 percent for home help.[12] He said that Norway plans to have nursing home beds for 7 percent of the 70-plus population.

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[9] Pages 14–15 of reference cited in footnote 1.
[10] Page 17 of reference cited in footnote 1.
[11] Page 23 of reference cited in footnote 1.
[12] Page 25 of reference cited in footnote 1.

Training in Geriatrics: The National Institute on Aging and the Senate Committee on Aging have, in the past, criticized shortcomings in geriatric training at schools of medicine in the United States.[13] Strong support for broadened educational opportunities in this field were expressed by several witnesses at the November 6 hearing. Sir Ferguson, for example, said that geriatric medicine in his country has been accepted as a specialty for higher medical training, that general practitioners receive postgraduate training in geriatric medicine, and that the majority of medical students receive specialized undergraduate training in geriatric medicine.[14] He said that there are now 10 university chairs in geriatrics within the United Kingdom[15] and emphatically recommended similar action in other nations.[16] Dr. Hollander commented:

> . . . it is especially necessary to prepare the physician to deliver appropriate care to the elderly, either being a general practitioner or a specialist in any field of medicine. He or she should have an appropriate knowledge of the basic principles and facts of the biology of aging. And I would like to stress that the same holds true for other disciplines working in this area, notably the nurses. No sophisticated system designed to deliver health care to the elderly will be optimal if those who have to deliver the care are not properly trained. (On the) contrary, it might be unusually costly because the health care is delivered without realizing if it is done in a proper way.[17]

Professor Chebotarev said:

> In accordance with the order of the U.S.S.R. Health Minister, issued this year, arrangements are being made for specialized training of medical personnel in geriatrics. As a state experiment, the geriatric medico-social centers are being organized in large cities. The order also provides for the organization of geriatric rooms at district outpatient departments. Their task is organizational, methodological, and consultative activity in geriatrics, dispensary care of all the aged, listed in the risk groups.[18]

Asked by Senator Domenici what more could be done to attract young medical students into geriatrics, Sir Ferguson responded:

> Health professionals particularly must look at the demographic projection. If a young man wants to take up medicine, then he must ask himself before taking up that profession if he is interested in the elderly. If he is not, then he would be well advised not to become a doctor, because the numbers of old people are going to be such that most of his patients will be elderly.[19]

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[13] See, for example, *Doctors in Nursing Homes: The Shunned Responsibility*, Supporting Paper No. 3 in a series, *Nursing Home Care in the United States*, Subcommittee on Long-Term Care, Senate Committee on Aging, February 1975, for recommendations to improve university training for treatment of older persons. For detailed discussion of the issue, see "Medicine and Aging: An Assessment of Opportunities and Neglect," transcript of a Senate Committee on Aging held in conjunction with the 29th Annual Meeting of the Gerontological Society, October 13, 1976, New York City, Senator Charles Percy, presiding.

[14] Page 14 of reference cited in footnote 1.

[15] Page 15 of reference cited in footnote 1.

[16] Page 41 of reference cited in footnote 1.

[17] Page 30 of reference cited in footnote 1.

[18] Page 20 of reference cited in footnote 1.

[19] Page 38 of reference cited in footnote 1.

SELF-HELP, AS WELL

Two witnesses described a growing role for older persons and family members themselves in maintaining their independence or semi-independence in later years.

Dr. Hermanova said that middle-aged family members can provide important support to disabled or semidisabled elders, but she added:

> We are feeling that something is missing in our courses on preparation for retirement. We inform people about social and economic changes which they face when they retire, we give them information on nutrition activities (physical and mental), but we do very little to prepare them for self-care and self-maintenance. And the skills of self-care and self-maintenance are so important for old men and old women, whose children leave and who lose their spouses. To be able to take care of one's own self means to be independent. And independence is the most important assumption for staying at home until high old age.[20]

Dr. R. Glyn Thomas of the World Health Organization foresaw shortages of personnel to deliver services to older persons in the home, and he supported the point made by Dr. Hermanova:

> The importance of educational programs for the aged themselves, beginning obviously long before they have reached the age of 80, and what we have called the importance of self-care or self-responsibility for health care within this particular group.[21]

C. Additional Issues

Asked primarily to deal with issues related to research, geriatric training, and health, roundtable participants also touched briefly upon other issues:

Dr. Gudmund Harlem of Norway praised the U.S. Congress for taking action which in effect would defer mandatory retirement from 65 to 70 (see chapter II for details). He said that nations should now give serious thought to restructuring pension systems:

> I am thinking about the necessity of having pension systems which do not lead to reduced total pensions if you continue to be active in paid work. This is to some extent a political problem because it leads to high total income for those who are fortunate enough to be able to work. But it seems as if such a system can be acceptable possibly because it gives future possibilities to all of us. At least it seems to be of decisive importance regarding achieving the goal of work activity also in high age, with all the benefits linked to such activity.[22]

Dr. Hollander foresaw the possibility of an upward movement in retirement age:

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[20] Page 28 of reference cited in footnote 1.
[21] Page 36 of reference cited in footnote 1.
[22] Page 25 of reference cited in footnote 1.

> The discussion in the Netherlands has been going on for years that there should be a lower age for retirement than 65 years. In a very recent meeting it was brought forward that a great part of the labor force never reached retirement age before retiring, because they went out earlier by ways provided in our social security system, meaning that the whole discussion, which is still going on, is partially sterile. It seems to depend on the type of work conducted.
>
> These are only preliminary data which need to be analyzed more in depth. However, if one looks to what happens in the population growth of industrialized nations, I envisage that retirement age automatically will go up because no nation can afford a social security system which lowers the retirement age. Therefore, it might happen automatically that we have to work a lot longer in life in the future, if we like it or not, due to the low birth rate in the industrialized nations.[23]

Professor Bourlière called for "retirement policies . . . flexible enough to cope with changing situations."

Dr. Henning Friis of Denmark said:

> We have the same discussions as are going on in the United States on the retirement age and its relation to the labor market situation of the elderly. Our surveys show clearly that the people between 40 and 65 demand a flexible age in the pension system. . . .[24]

Dr. Hermanova said:

> Great attention is paid to employment in old age, which is considered to be more than gainful activity, but which includes contacts with other people and provides opportunity to use all maintained capabilities in a useful way. People over 60—60 is a common age for retirement in Czechoslovakia—cannot be forgotten as a possible labor force but, of course, in positions corresponding to their individual functional potential. Our social legislation has already adopted the first steps in order to realize the gradual retirement. Pensioners may work 180 days per year without any pension cut; in some manual professions, the whole year.[25]

Dr. Alvar Svanborg of Sweden—describing a study of people over age 60 in the second largest city of his nation, Gothenburg—said the researchers had found "that every sixth woman in our society was living in a situation of loneliness and physical and intellectual inactivity to such an extent that it must have influenced basic physical and mental functions. The fact that every sixth woman at the age of 70 . . . declared that one or more days could pass without contact with others is definitely an example of such a degree of social isolation." [26]

Forty-eight percent of the respondents in the study cited by Dr. Svanborg said that their only hobby after retirement was reading.

Dr. Thomas said that the European regional office of WHO has been given the responsibility for development of a global program in health care for the elderly. One problem already encountered by WHO is

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[23] Page 46 of reference cited in footnote 1.
[24] Page 29 of reference cited in footnote 1.
[25] Page 23 of reference cited in footnote 1.
[26] Page 34 of reference cited in footnote 1.

that "we have masses and masses of data with very little meaningful information. For example, it is very difficult to obtain direct sex-related and age-related information. Nearly all of this is quoted as 65 and over, implying that we are dealing with a homogenous group when, in fact, we are not." [27]

WHO will sponsor regular information and exchange meetings among nations.

Participants placed heavy emphasis on the importance of the family and referred to cross-national surveys showing that most adult offspring stay in fairly close touch with elderly parents. But with increases in disability among the very elderly, family members may sometimes, as Sir Ferguson expressed it, become "stressed," causing them to stand in need of assistance:

> I think this is terribly important. We must always fight for the preservation of the family. We must not say the old lady has a daughter, therefore we don't need to help. The daughter may need help. We must aim at preserving the family unit.[28]

D. An Additional Challenge

An NIA summary of the directors' meeting in Bethesda posed an overall challenge to factfinders and educators in gerontology:

> . . . too many people, especially government leaders, appear to view the problems of aging in economic or social terms, accepting the medical problems now associated with aging as inevitable. Thus there is an ever-increasing need to demonstrate to these people the link between medical research and better therapy and health services. The complex problems of aging require a balanced, multidisciplinary attack. A program balance between the needs of our present elderly and the problems of an even larger number of aged in the future must also be achieved. Nutrition, pharmacology, prevention of the disabilities of aging, and the retirement crisis are of interest to many of the groups represented.

II. U.N. ACTIONS ON AGING

Additional impetus for international attention to aging was generated during 1977 by several actions related to the United Nations.

Ever since 1973—when the U.N. General Assembly adopted a resolution (3137–XXVII) requesting the Secretary-General "to undertake studies . . . regarding the interrelationship between demographic social, and economic factors in aging"—the U.N. program in aging thus established has increased in scope and support.

A. Broadened U.N. Program in Aging

That trend continued in December 1977 when the General Assembly accepted its Economic and Social Council's draft resolution instructing the Secretary-General "to pursue, expand, and consolidate his

[27] Page 37 of reference cited in footnote 1.
[28] Page 43 of reference cited in footnote 1.

work on the status of the elderly, particularly with regard to research and exchanges of information." [29]

In addition, the U.N. in 1977 issued a report [30] about increased populations of the aging in slums and "squatter settlements" throughout the world. Additional attention was to be focused in 1978 on comparisons of aging in developing and developed regions of the world.[31]

B. U.S. Congress Support for a World Assembly on Aging

Impressed with growing U.N. concern about aging-related issues, Senator Frank Church introduced a Senate Resolution (238) on August 3, 1977, asking the President to instruct the U.S. delegation to the U.N. to work with other delegations to support a World Year on Aging and a World Assembly on Aging in 1982. He cited the U.N.'s "encouraging actions to broaden its research and information program on aging," and said that the forthcoming General Assembly deliberations of the question of a broadened program on aging "should serve as an appropriate vehicle for a discussion" of his proposal.

He added:

> . . . public policy issues related to aging require an international exchange of information and proposals for individual cooperative action. I emphasize that the World Assembly would be a meeting of nations; it would *not* be an exchange of information by research scientists. That purpose is admirably dealt with by triennial meetings of the International Congress of Gerontology.[32] What is also needed is communication among political leaders and government specialists who, more and more, will find that the "aging" population throughout the world has already begun to cause significant and sometimes startling social and economic changes requiring immediate and long-term attention.

The Senate approved the Church resolution on October 5.[33] Claude Pepper, chairman of the House Select Committee on Aging, introduced a similar resolution (H. Res. 736) which won House approval on October 31. Representative Pepper commented:

> Mr. Speaker, the United States should take the lead in recognizing the need to enhance communication between policymakers, from many lands, to benefit from their insights with respect to methods, approaches, and techniques

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[29] For information about action taken by the General Assembly at its 31st session (September-December 1976) and by the U.N. Commission for Social Development at its 25th session (17 January–4 February 1977) on the question of aging, see AGING: BULLETIN ON AGING, issued by the Social Development Division, Center for Social Development and Humanitarian Affairs, Department of Economic and Social Affairs, United Nations Secretariat, July 12, 1977. The bulletin includes a summary of the Commission's debate on aging.

[30] "The Aging in Slums and Uncontrolled Settlements," U.N. Department of Economic and Social Affairs, 1977. This report describes growing concentrations of older persons in "decaying areas of urban centers." In New York City, for example, the U.N. found that 40 percent of the 1 million older residents live in slum areas. In Vienna, "the aging tend to live in the most densely populated parts of the older working class districts." The report defines "squatter settlements" as "usually new areas built by their own inhabitants on unoccupied land which is either urban property that could be developed or in peri-urban areas." It also said that squatter settlements are by far the fastest growing parts in urban areas of the developing world, and that the numbers and proportions of the elderly "appear to be increasing as urban growth in general, and growth of slums and squatter settlements in particular, accelerate."

[31] Under the auspices of the U.N. Fund for Population Activities, an Expert Group Meeting on Aging will be held in April 1978 "to identify ways and means to foster and promote technical cooperation among and between the developed and developing regions in this field."

[32] The next such Congress will be held in Tokyo, Japan, during August 1978.

[33] P. S13457, Congressional Record Aug. 7, 1977.

of improving the lot of elderly people throughout the world, whether it is with regard to improved health, status, income maintenance, housing, or simple social acceptability.

What this resolution does is to focus world attention upon the needs for elderly people, wherever they are, so that they will have an opportunity to render a valuable contribution to their countries and to their society and to their times.[34]

On December 6, 1977, Congressman Charles W. Whalen—U.S. Representative to the United Nations, in the third committee—urged action along the lines set forth in the Senate and House resolutions. He said that national goals on aging would benefit from a "strong program of interchange in this field," and added:

As we achieve our goals in terms of better health, better living conditions, and a better life, we are going to have an increasing number of people who, having labored hard for their countries and themselves, can no longer participate actively in the development of their societies. We cannot, we must not ignore them or their problems. They deserve well from us, and we should focus our attention on them now and not wait until their numbers and difficulties become acute.

The General Assembly, on the same day, accepted the U.S. resolution asking member nations of the U.N.:

. . . to make their views known to the Secretary General by 1 July 1978 concerning the utility of proclaiming an international year on aging for the purpose of calling worldwide attention to the serious problems besetting a growing portion of the populations of the world; and further invites all States to communicate their views to the Secretary General by 1 July 1978 regarding the desirability of convening a world assembly on aging in order to permit national leaders and government specialists to exchange experiences, explore solutions, and devise programs for amelioration of the problems unique to the elderly.

The Secretary General is to prepare a report based upon reactions of member states and make "appropriate proposals on ways in which either or both of these undertakings might be carried out."

III. A U.S. WHITE HOUSE CONFERENCE ON AGING?

Senator Church and Representative John Brademas [35] took action in 1977 on another call for organized and intensive attention to aging.

On May 6, the Senator introduced S.J. Res. 48, calling for a White House Conference on Aging in 1981, as did the House resolution introduced on the same day by Representative Pepper.

Both Senator Church and Representative Pepper cited National Conference on Aging called by President Harry S. Truman in 1950, a White House Conference called by President Eisenhower in 1961, and another called by President Nixon in 1971.

Representative Pepper commented:

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[34] Page H11838, Congressional Record, Oct. 31, 1977.

[35] Representative Brademas, with 10 cosponsors, introduced H.J. Res. 428, calling for a White House Conference in 1981, on May 2, 1977.

> The House Select Committee on Aging . . . has just finished line-by-line study of the 1971 report. Although much progress has been made as a result of these recommendations, we find a great many of them still unimplemented almost 6 years after the close of the conference.[36]

Senator Church called for intensive factfinding efforts well in advance of a 1981 conference:

> This White House Conference on Aging must include a more substantial effort to provide conferees and other policymakers with necessary information about the true status of older Americans in income adequacy, housing, health care needs, and other key areas. Conferees must also have access to the best and most up-to-date information on the status and effectiveness of our current efforts. All too often, participants in the 1971 White House Conference on Aging needed essential data to help steer policy discussions and recommendations. But this information was frequently unavailable. This was particularly true on issues concerning the minority elderly and housing.
>
> My resolution specifically requires the Secretary of HEW to determine what information will be needed by the conferees, and to commission special studies to evaluate the adequacy of statistical resources and provide needed information on a timely basis to conferees at the local, State, and national levels. There is still time to participate in the design for the next census, if we know what information is needed. There is still time to conduct special research studies to provide essential data for important legislative and policy decisions.[37]

Strong support for the White House Conference on Aging resolution was expressed by several representatives of national organizations on aging at Senate hearings on extension of the older Americans Act before Senator Eagleton's Subcommittee on Aging, Committee on Human Resources. For example, the executive director of the National Council on the Aging testified on February 8:

> It is the public participation, especially of the elderly in the State and local conferences, that insures the vigor and responsiveness of the conference to older people's needs. But our time for these important local conferences is running short. Senate Joint Resolution 48, calling for a 1981 White House Conference on Aging, was introduced in May of 1977, yet has received little committee attention. We call on Congress to act swiftly on this resolution so that plans for the conference can get under way.

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[36] Congressional Record, May 3, 1977.
[37] Ibid.

FINDINGS AND RECOMMENDATIONS

Worldwide attention to aging, in coordinated and comprehensive fashion, is urgently needed, not only because of readily foreseeable demographic changes which will have far-reaching social and economic impact, but also because of the positive improvements that the "Graying of Nations" can bring.

—The U.S. National Institute on Aging and other appropriate Federal units be encouraged by the Congress and the executive branch to continue to facilitate international exchange of information on aging and research findings;

—The U.S. delegation to the United Nations continue its leadership role in encouraging U.N. consideration of a World Year and a World Assembly on Aging;

—The U.S. White House Conference on Aging legislation be approved by the Congress at an early date, primarily to develop information and recommendations needed to refine national goals and policies on aging, but also to transmit its conclusions to the cross-national deliberations on aging now occuring with deepening intensity within and among nations.

ADDITIONAL VIEWS OF SENATOR MUSKIE

Although I have approved publication of this report, I have reservations about some of the recommendations set forth, especially the proposals to establish an independent Social Security Administration and to provide semiannual cost of living adjustments during periods of rapid inflation. The report and its recommendations merit the attention and the consideration of the Senate and the public. I will make my judgment on each of these recommendations on the basis of the dialogue and analysis that this report provokes.

SUPPLEMENTAL VIEWS OF MESSRS. CHILES AND DOMENICI

While not wishing to differ with any specific provisions in this annual report, we do want to emphasize one important area of concern, namely the impact of Federal spending and the current inflation rate on elderly Americans. As members of the Senate Budget Committee we have been on the cutting edge of one of the most significant restructuring of Congressional procedures in recent decades. Our ability to gain an overview of total Federal fiscal and monetary policies and their impact on the performance of our Nation's economy has led us to conclude that further efforts to control Federal spending will, over the long run, serve the best interests of older Americans.

Throughout this decade, the American economy has run an unacceptably high level of inflation and that trend continues to this day. Over the last eight years, three different national administrations have applied a variety of monetary and fiscal policies designed to reduce the rate of inflation without imposing upon our Nation an unacceptably high level of unemployment. Our efforts to develop a workable national economic policy have been complicated by a number of factors, not the least of which was the transition from a war to a peacetime economy and the severe recession of 1974–75. Over the past several years there has been a gradual reduction in the inflation rate, but recent statistics have raised new fears that inflationary pressures will rise again in the months ahead.

One of the major concerns of older Americans is, quite understandably, the adequacy of their retirement income. For most retired Americans, Social Security provides all or almost all of their post-retirement income. Even those who have supplemented their fixed retirement incomes find it increasingly difficult to make ends meet in an inflationary situation. Living as they do on fixed incomes, the retired elderly individual has a more difficult time supplementing his or her meager income to offset the rising costs of living than does his younger counterpart in our society.

If this trend continues we run the risk of reducing more and more older Americans to the status of welfare recipients. Such a process would greatly expand their dependency upon the government and convert them into virtual wards of the state, and would be a very distressing occurrence for millions of older Americans who have been independent, self-reliant, productive citizens throughout their lives. We believe that today's older Americans are members of the generation most responsible for our Nation's greatness. They worked on our farms and in our factories, they sacrificed during periods of depression and war, and they fought around the world to protect the cause of freedom from various forms of totalitarianism. Their independence and self-reliance will not yield easily to a growing dependency on the state.

We recognize that Social Security benefits, railroad retirement benefits, Civil Service benefits and Supplemental Security Income benefits are, in varying degrees, adjusted to compensate for inflation. In some cases this may prevent the person from losing ground economically during a period of rapid inflation. However, the Committee has found that for most older Americans, the cost-of-living adjustment does not fully compensate the recipient for his or her loss of buying power. Thus we are confronted by a situation in which the living standard of many older persons gradually declines after retirement in face of inflation.

The Budget Committee has, as part of its responsibility, the task of overseeing the inter-relationships of various economic forces. We obviously focus a great deal of our attention on the outlays contained in the Federal budget. We also must review revenue estimates, economic growth patterns, unemployment, inflation, and the size and impact of the Federal deficit.

We have found that in many cases, especially in programs affecting the elderly, we may provide a modest benefit or service on the one hand while depriving that person of a comparable benefit with the other. Our goal today must be to continue to reduce the rate of inflation until we come as close as possible to the goal of price stability.

We suspect that, for the vast majority of older Americans, a higher degree of price stability would do more to help them meet their individual needs than any other course of action the government might pursue. This does not mean that we should not maintain and strengthen the "safety net" of government programs and services which are there to help senior citizens who cannot live with a reasonable degree of comfort on their own resources. That "safety net" should be strong and it should be in place nationwide, so that it will help senior citizens who need such services wherever they may live.

We recognize the value of, and have long supported, numerous programs designed to provide social and nutritional services to older Americans. These programs have, for the most part, produced good results and the growing Federal/State/local aging "network" holds the promise of future progress in our ongoing effort to improve the quality of life of our senior citizens. As fine as these programs are, we must never lose sight of two very important facts: (1) the existing service programs touch the lives of a relatively small percentage of older persons, and (2) the vast majority of senior citizens are able to meet their own basic needs—and maintain themselves in relative comfort—without direct or frequent assistance from government programs. However, the well-being of most retired persons is closely related to the health of the overall economy. It is incumbent upon Congress to provide a stable economy, control inflation, and curb rising prices in order for older Americans to achieve financial security.

We believe that Congress could do more to improve the quality of life for older Americans by striving to achieve greater price stability. If the new budget process, coupled with a greater public awareness of the need for budgetary restraint, moves Congress in the direction of greater fiscal responsibility it will have made a valuable contribution to the future strength of our economy.

LAWTON CHILES,
PETE V. DOMENICI.

SUPPLEMENTAL MATERIAL

Supplement 1

MATERIAL RELATED TO TRANSPORTATION ISSUES

ITEM 1. LETTER FROM SENATORS FRANK CHURCH AND LAWTON CHILES, TO HON. BROCK ADAMS, SECRETARY, DEPARTMENT OF TRANSPORTATION, DATED APRIL 15, 1977, AND REPLY DATED MAY 17, 1977

DEAR MR. SECRETARY: We are writing to you in regard to an issue which the committee has been following closely and which is of vital importance to millions of older Americans—the design characteristics of the Nation's bus fleet. As you are undoubtedly aware, a significant segment of the elderly population finds it difficult or impossible to utilize presently available buses. Committee hearings have revealed time and again that the absence of affordable, accessible transportation condemns millions of these citizens to becoming prisoners in their own homes. The resultant isolation from friends, family, shopping, health care, and social services frequently produces physical and emotional deterioration and unnecessary institutionalization, often at high cost to the Federal Government.

We were pleased to learn that you had delayed the implementation of the regulations issued by UMTA on July 27, 1976, and had committed the Department to a through reexamination of this issue and the promulgation of new regulations by May 27. Your action clearly indicated that you did not feel bound by the policies of a prior administration, particularly when they have resulted in two major lawsuits alleging that those July regulations did not implement the clear congressional mandates that they promote the equal rights of the elderly and handicapped to utilize transit services as well as effective competition in this field of manufacture.

We urge you to issue regulations on May 27 which implement those mandates. New bus design standards must accomplish more than simply the cosmetic alteration of presently available vehicles. America's technological capability is surely sufficiently developed to provide transit buses which can be easily and safely utilized by the overwhelming majority of Americans, no matter what their age or physical handicap. We can see no reason why, when tax dollars provide 80 percent of the capital cost of these buses, taxpayers should be excluded from their use.

We would hope that these regulations specify the earliest possible date for commercial production of such vehicles. In the interim, procurement policies should be designed to allow the purchase of the best available buses while insuring the economic viability of the present three American manufacturers. While these manufacturers

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should be permitted to pursue their own innovative paths to the goal of barrier-free access, we firmly believe that new design features for the elderly and handicapped should be normal maintenance items incorporated on all vehicles and not add-on features to be installed on merely a select percentage of new buses. In addition, consideration should be given to retrofitting existing buses with significant remaining lifespans so as to provide better access.

Although we are firmly committed to implementation of the Biaggi amendment at the earliest possible date, we believe that special transportation services, such as those developed under UMTA's section 16(b)(2) program, have a continuing role to play in the overall transportation system. Such services will complement even a full-access bus fleet by providing necessary transit for those elderly with severe disabilities or who reside in areas characterized by remoteness, adverse terrain, or high crime.

Mr. Secretary, by issuing regulations which fulfill congressional intent you will be assisting all citizens, not just the elderly and handicapped. Buses which incorporate state-of-the-art design and technology will be better, safer, and more comfortable vehicles. An attractive and convenient bus fleet can be a vital component in the President's energy conservation program.

Yet, these many practical considerations aside, we believe that it is the constitutional principle of equal protection which dictates that America proceed to develop transit services usable by all citizens as rapidly as possible.

Sincerely,

FRANK CHURCH, *Chairman.*
LAWTON CHILES.

THE SECRETARY OF TRANSPORTATION,
Washington, D.C., May 17, 1977.

Hon. FRANK CHURCH,
Chairman, Special Committee on Aging, U.S. Senate, Washington, D.C.

DEAR FRANK: I appreciate your thoughtful letter of April 15, cosigned by Senator Chiles, indicating your support of Transbus and your concern that mass transit buses be accessible to elderly and handicapped persons.

As you know, when this Administration took office in January we found that the Transbus program was no longer being actively pursued and certain accessibility standards for the elderly and handicapped were schelduled to become effective on February 15. Many of the spokesmen for those groups alleged, however, that those standards did not meet their needs.

On February 14 I announced that I would reopen the Transbus issue, hold a public hearing on the matter on March 15 and announce a decision on May 27. The accessibility standards relating to floor and step heights were waived until after that date. At the March 15 public hearing, we heard testimony from more than a dozen elderly and handicapped groups and I am, of course, considering their views very carefully in preparing a decision.

On March 14, I announced an interim bus acquisition policy which would permit the procurement of advanced design buses which represent the current state-of-the-art. Previous attempts to acquire such buses had resulted in protracted litigation (recently decided in favor

of the Department of Transportation's position) and the consequent inability of any city to acquire advanced buses offering improved accessibility for the elderly and handicapped.

In announcing these actions I have repeatedly committed myself to developing a policy which insures continuation of viable competition among domestic bus manufacturers, encouragement of advanced technology in bus design and accessibility for all mass transit riders. My decision on May 27 will also reflect those concerns, and I will be pleased to forward a copy of it to you then.

I am grateful to you for taking the time to let me know your views on this matter and I assure you they will receive full consideration.

Sincerely,

BROCK ADAMS.

ITEM 2. DECISION OF BROCK ADAMS, SECRETARY OF TRANSPORTATION, TO MANDATE TRANSBUS, DATED MAY 19, 1977

INTRODUCTION

The question before me is whether to mandate or encourage the acquisition of a low-floor, ramped bus (Transbus) by all local transit authorities seeking Federal assistance for the purchase of standard-size mass transit buses, after a certain date. Further questions include: if Transbus is mandated, what should be (i) the effective date of the mandate; (ii) the design of the bus; (iii) the Federal role in introducing the bus; and (iv) the interim bus acquisition policy.

In 1971, the Urban Mass Transportation Administration (UMTA) of the Department of Transportation (DOT) initiated a major research project to develop an improved transit bus that would attract mass ridership, be accessible to those elderly and handicapped persons for whom the high floors and stairs of current buses provide serious obstacles and encourage continued competition among the manufacturers of transit buses. UMTA enlisted the aid of the three major domestic bus manufacturers, AM General, General Motors and the Flxible Co. (a wholly-owned subsidiary of Rohr Industries), to supply prototypes of such a bus for testing. Prototypes were built by all three manufacturers, tested by UMTA contractors and demonstrated in actual service in four cities. This process enabled the development of draft specifications for production of Transbus.

In July 1976, Robert E. Patricelli, who was then UMTA Administrator, announced that DOT would not mandate Transbus. Instead, the agency would permit the introduction of an advanced design bus (ADB), would mandate requirements for making buses accessible to elderly and handicapped passengers (to become effective on February 15, 1977) and would provide funds for research and development of under-the-floor components that would be needed by a low-floor bus in the future. This decision generated considerable public discussion. Many elderly and handicapped groups asserted that the bus accessibility requirements were unsatisfactory. Litigation was initiated challenging UMTA's authority to fund acquisition of ADB's. Work on developing Transbus came to a virtual halt.

Shortly after I was sworn in as Secretary of Transportation in January, I took several steps to address these issues. First, I announced that the decision against mandating Transbus would be

reconsidered and a public hearing on the matter would be held on March 15. Second, I waived that portion of the regulations on accessibility for the elderly and handicapped that might have been inconsistent with a future decision on Transbus, until after that decision was made. Third, I initiated new policies and procedures for the interim acquisition of ADB's. A decision on Transbus was promised by May 27.

In reviewing this matter I have had available to me the record on which former Administrator Patricelli based his decision, the transcript of the March 15 public hearing, written material subsequently submitted for the record, summaries of staff discussions with interested parties, also in the record, and, of course, the relevant statutes which I am responsible for administering.

THE DECISION

After carefully weighing the data and views submitted by manufacturers, the American Public Transit Association (APTA), individual transit authorities, groups representing the elderly aud handicapped and others, I have decided, for the reasons stated below, to mandate Transbus. This mandate will take the form of requiring the use of a Transbus specification for all standard-size buses acquired with UMTA assistance. The mandate will apply to all procurements containing vehicle specifications approved by UMTA, issued for bid after September 30, 1979. The specifications already developed after consultation with APTA and others will be used with some minor modifications. The specifications include a requirement for a stationary floor height of not more than 22 inches, for an effective floor height including a kneeling feature of not more than 18 inches, and for a ramp for boarding and exiting.

Additionally, I have decided that DOT should encourage the formation of groups of purchasers to make the initial purchases of Transbus through advertised, low-bid competitions. Progress payments will be permitted for these initial purchases. Finally, I have decided to leave in effect the interim policy on accessibility for the elderly and handicapped. That is, manufacturers must continue to offer optional wheelchair lifts, and local transit authorities must either purchase buses with lifts or provide special services for elderly and handicapped passengers. Each of these decisions is discussed more fully below.

THE STATUTORY FRAMEWORK

In 1964, Congress responded to a growing pattern of declining ridership and increasing financial difficulties in the Nation's mass transportation systems by enacting the Urban Mass Transportation Act of 1964 (UMT Act). There have been several major amendments since 1964, and, as amended, it continues to provide the legislative basis for the Federal role in urban mass transportation. Section 2 of the UMT Act states that its purposes are: to assist in the development of improved mass transportation facilities, equipment, techniques, and methods; to encourage the planning and establishment of areawide mass transportation systems needed for economical and desirable urban development; and to provide assistance to State and local governments and their instrumentalities in financing such systems.

To accomplish these purposes, sections 3 and 5 of the UMT Act authorizes grants to State and local public bodies to assist in the

financing of mass transportation related capital facilities including standard-size transit buses. The Federal share of a capital facilities grant under section 3 is 80 percent of net project cost. Under section 5, which also authorizes payments for operating assistance, the Federal share of a capital facilities grant is a maximum of 80 percent of net project cost.[1]

Section 6 of the UMT Act, under which the Transbus research activities were funded, authorizes research, development and demonstration projects in all phases of urban mass transportation. Section 9 authorizes grants for urban mass transportation planning and technical studies.

A 1970 amendment to the UMT Act declared the mass transportation needs of elderly and handicapped persons to be of national importance and required DOT to exercise a special leadership role to insure that their rights were protected. This 1970 amendment added section '6 to the act to read, in part, as follows:

> Section 16. (a) It is hereby declared to be the national policy that elderly and handicapped persons have the same right as other persons to utilize mass transportation facilities and services; that special efforts shall be made in the planning and design of mass transportation facilities and services so that the availability to elderly and handicapped persons of mass transportation which they can effectively utilize will be assured; and that all Federal programs offering assistance in the field of mass transportation (including the programs under this act) should contain provisions implementing this policy.

Equally important, section 504 of the Rehabilitation Act of 1973 established the right of every handicapped person to be free of discrimination in any federally-assisted program. Section 504 reads:

> No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Shortly after the adoption of section 16, DOT began implementing the legislative mandate requiring special Federal leadership in the area of mass transportation for elderly and handicapped persons through written guidelines for UMTA grantees. UMTA also financed research and studies in the area. In April 1976, the earlier guidance to grantees was formalized and strengthened by the publication of UMTA's regulations on transportation for elderly and handicapped persons. These regulations set forth a comprehensive scheme of planning, service and design requirements.

DOT has long recognized that a low-floor, standard-size bus that provides access for nonambulatory and wheelchair-bound passengers would be an effective means to accommodate these several statutory mandates. The Transbus program was initiated, at least in part, to test the feasibility of such a bus. Of the methods of accomplishing accessibility that were studied and demonstrated in the Transbus program, UMTA acknowledged that the ramped Transbus emerged

[1] The Federal-Aid Highway Act of 1973 also authorizes capital assistance to mass transportation including assistance to acquire standard size transit buses.

as the most desirable. The ramp was nonetheless not required in the specifications that were subsequently developed. The existing statutory mandates regarding transportation for the elderly and handicapped and the proven feasibility of a low-floor, ramped Transbus that will result in substantial benefits to the able-bodied as well as the disabled, argue convincingly for a Transbus mandate.

Section 16 of the UMT Act, section 504 of the Rehabilitation Act and other statutory provisions have resulted in a number of lawsuits brought by elderly and handicapped persons. Although DOT has generally been successful in that litigation, litigation success alone provides no reason to avoid or defer a Federal mandate of technological improvements as they become available, especially when, as here, those improvements significantly advance the mass transportation interests of all persons, including the elderly and handicapped, and when the improvements are quite unlikely to be introduced without a Federal mandate.

There is one additional statutory reason, apart from improved accessibility, for mandating Transbus. First, DOT has a statutory obligation to assist in the development of improved mass transportation facilities and equipment. Until the recent introduction of ADB's there had been essentially no change in bus design since the advent of the "new look" bus in 1959. The advanced designs presently being offered are logical intermediate steps on the way to the introduction of Transbus, and in fact, they are in part outgrowths of the Transbus program. Yet these advanced designs fall short of accomplishing one of the major goals of the Transbus program—a low-floor with attendant benefits in boarding and exiting for all passengers. Thus, a Transbus mandate will bring to fruition the full benefits of federally-assisted research and development in the area of standard-size buses.

Finally, as the transit bus market has moved to new levels of product improvement, it has become increasingly difficult to fashion procurement methods since ADB's are of somewhat different designs, with different levels of performance and, quite naturally, different prices. A Transbus mandate will provide the necessary Federal leadership in the marketplace to allow transit bus manufacturers to plan investments and tooling costs around certain required minimum performance and design characteristics. This, in turn, will permit low-bid procurements that will assist in the maintenance of a viable and competitive bus manufacturing industry based upon a predictable Federal policy.

THE NEED FOR A MANDATE

A review of the history of the Transbus program convinces me that simply encouraging Transbus will not result in its prompt introduction and may not result in its introduction even in the long run. Even after approximately $27 million of UMTA investment, all serious efforts toward producing Transbus stopped when UMTA announced in July 1976 that it would not be mandated. The history of change in bus design is not one of constant innovation. As noted earlier, the so-called "new look" bus, the one currently in use, was introduced in 1959.[2]

[2] The lack of innovation in bus design prompted a study by the National Academy of Engineering (NAE) documenting the need for an improved transit bus. The NAE study concluded that a low-floor bus was: "The most desirable means—within the existing state of the art—for improving bus transportation." The low-floor, the NAE noted, would result in a bus that was "not only . . . easy and comfortable to use, but usable readily and without embarrassment by the physically and economically handicapped, the aged, the pregnant woman, the businessman, and the young adult."

ADB's will not be on the streets for another year and do not offer the advances of Transbus.

A review of the statutes that guide this decision suggests strongly that any inclination to postpone a mandate further would thwart the intent of the Congress. A review of recent litigation suggests equally strongly that the courts are also not prepared to countenance needless delay in making urban mass transit vehicles accessible to the elderly and handicapped.

Even if the congressional and judicial concerns were not as clear as they are, I believe it is my responsibility to insure to the extent feasible that no segment of our population is needlessly denied access to public transportation. It is now within our technological capability to insure that elderly and handicapped persons are accorded access to urban mass transit buses. This access is fundamental to the ability of such persons to lead independent and productive lives. In my view, a decision assuring that access could have been made some years ago.

Today, the ADB represents the state-of-the-art in bus design from the floor up. But their floor height (even with a kneeling feature) does not make them accessible to the elderly and handicapped without a wheelchair lift. The lift is an expensive piece of hardware, principally benefiting those in wheelchairs. Many of those individuals, however, regard the lift as degrading and have expressed concern about the difficulty and safety of using it. In addition, use of the lift slows bus operations since it takes time to deploy and other passengers cannot board or exit during that time.

The low-floor Transbus can, on the other hand, accommodate a ramp. The ramp is swift to deploy and can be used beneficially by many passengers, including most categories of mobile elderly and handicapped. A low-floor, ramped bus will decrease the loading and unloading time for all passengers.

It is important to keep in mind that in discussing bus accessibility for the elderly and handicapped we are not concerned only with those confined to wheelchairs. We are concerned as well with any mobility-impaired person, a group which numbers at least 10 million. At any time there may be many other riders who are at least temporarily disabled. We cannot deny these people the rights that so many others enjoy when it is within our ability to accord them such rights.

I am acutely aware that many who are opposed to Transbus argue that it is not now within our ability to produce a low-floor, ramped bus which can operate safely and efficiently in day-to-day transit service. These objections are discussed in detail below and, in my judgment, satisfactorily refuted.

Further, a Transbus mandate does not interfere with the traditional responsibility of local officials to plan for and implement mass transportation projects. Routes, schedules and fares continue to be matters of local decision and State and local officials retain the authority to plan for and implement all transit services including specialized services where these can contribute to overall mobility needs. For those communities utilizing standard-size bus service over fixed routes the Transbus will permit faster and more efficient bus service by minimizing the time required to take on and discharge all passengers, in-

cluding those who are elderly or handicapped. Better accessibility, new styling features and a better ride will attract and retain new ridership, add to the operating revenue of transit operators and enhance the image of mass transportation in every community. Moreover, testimony at the public hearing, as well as a number of comments on the Transbus question, indicate that several communities have been and continue to be vitally interested in obtaining low-floor standard-size buses, but have been unable to do so because of the commercial unavailability of Transbus. A Transbus mandate will permit DOT to be responsive to these locally conceived mass transportation objectives, as comtemplated by the UMT Act.

THE EFFECTIVE DATE OF THE MANDATE

The record of the March 15 hearing (and the hearing conducted by UMTA in 1976) contains conflicting projections of when Transbus could be ready for production. AM General indicates that Transbus could be available approximately 34 months from the date of a mandate. Flxible says 36–60 months, and General Motors says 5 years. These manufacturers have different views about the desirability of Transbus and the adequacy of ADB's, and their existing investments reflect these judgments.

My analysis of the entire record convinces me that all three current manufacturers could begin deliveries in 3½ years. This date allows almost 2½ years for development before bidding would begin, and approximately 15 months thereafter before the buses are actually delivered.

As I said in my opening remarks at the Transbus hearing, we have a very competent bus manufacturing industry and I believe competition, as well as innovation, must be encouraged. I am certain that these manufacturers can meet the challenge of producing Transbus. Additionally, I believe the pressure of effective competition among the manufacturers will result in a prompt introduction of this needed improvement. If one manufacturer is ready substantially before the effective date of the mandate, we will consider sole source procurements to get Transbus on the streets as soon as it is available.

Accordingly, as I stated above, I am ordering that all bus procurements utilizing UMTA capital assistance funds must use the Transbus specifications after September 30, 1979. I urge those manufacturers who can to make Transbus available voluntarily at an earlier date.

THE DESIGN OF TRANSBUS

In connection with the research effort to develop Transbus, UMTA developed a complete procurement document—the Transbus procurement requirements (TPR)—for use by local transit authorities in buying Transbuses. The document contains four parts:

Part I.—Bid requirements/contractual provisions: Provides legal and other instruments for procuring coaches;

Part II.—Technical specifications: Specifies the buses being procured;

Part III.—Quality assurance provisions: Specifies the minimum quality control requirements in the manufacture of the buses; and

Part IV.—Warranty provisions: Describes the warranty coverage on the buses after their acceptance by local transit authorities.

The TPR was developed for DOT by Booz-Allen Applied Research with full participation by the APTA Bus Technology Committee, AM General, General Motors, Flxible, and UMTA. It was designed to be used by procuring agencies in competitive procurements of Transbuses under the UMTA capital grants program.

It was originally intended that the Transbus prototypes developed by each manufacturer would be tested and evaluated and a winning design selected for use by all manufacturers. However, while the three Transbus manufacturers met the performance requirements for Transbus prototypes, all three used different approaches based on their individual body styling, construction and manufacturing techniques. UMTA concluded that to require all three manufacturers to build buses around one manufacturer's design would put two of the manufacturers at an unnecessary competitive disadvantage and would stifle innovation. Thus, the design specification approach was abandoned on January 8, 1975, when UMTA announced a policy which would permit all three designs to qualify for production if they met a performance specification to be developed by UMTA as a result of testing and evaluation of the prototype vehicles.

The specifications that were developed as a result of this decision nevertheless include certain design requirements such as floor height, door width, step riser height and tread depths intended to insure that accessibility goals are met. The specifications include options for features such as power plant size, air-conditioning, bus width, bus length, etc. The TPR requires every manufacturer to be able to bid on any specified combination of options in direct cost competition. The specifications are intended to be modified, from time to time, as improved components or designs are developed.

I am today adopting, with some modifications, the specifications developed and set forth in the TPR. The most important modification is the one which makes the ramp a mandatory feature of the bus. The TPR, as modified, will be available from UMTA on June 13.

In my judgment, use of this specification will promote the earliest availability of Transbus without stifling innovation in manufacture and design.

THE FEDERAL ROLE IN INTRODUCING TRANSBUS

As I indicated above, DOT has already invested approximately $27 million in the Transbus program. As a result of that investment we have learned what is and is not technologically feasible in connection with development of a low-floor, ramped bus. We have identified the problems of the prototype buses as well as solutions to them. We have determined which components need further development, and which are presently able to be produced. In my judgment, the $27 million was well spent.

I am aware that costs remain in connection with going to production models of Transbus. I am convinced, however, that this type of cost should properly be borne by the manufacturers. Direct Federal funding for tooling and startup costs is not appropriate given the knowledge and experience already gained through the DOT investment. Product quality, production methods and related matters are and should be uniquely the responsibility of the manufacturer.

This would not be the case had the Federal investment not already proven the underlying feasibility of Transbus. We could not reasonably

require manufacturers to invest in a wholly unproven technology. But, as discussed more completely elsewhere, I am convinced the technology for Transbus is proven and consequently I believe it appropriate to require the manufacturers to put that technology into production.

There is, however, another important responsibility for the government to undertake in introducing Transbus into the marketplace. We should, I believe, do everything feasible to assure early purchases of substantial numbers of the first production Transbuses. To this end, we will encourage formation of purchaser groups to make initial procurements of Transbuses from each manufacturer through advertised, low-bid competitions. While I do not think it is appropriate to allocate the market in an effort to guarantee that each manufacturer's bus will be bought, we will permit each consortium to make initial Transbus purchases from more than one manufacturer if the consortium members so desire.

Additionally, we will agree to make progress payments in connection with these initial purchases to help defray startup production costs. As I have already stated, we will also consider making sole source procurements of any manufacturer's Transbus which is available substantially earlier than the others.

I believe that these steps represent the maximum necessary federal role in introducing Transbus.

INTERIM ACCESSIBILITY POLICY

I am aware that even after Transbus is mandated purchases of conventional buses will continue, with UMTA financial assistance, for slightly more than 2 years. Inasmuch as these newly purchased buses will continue in operation for 12 or more years, I believe it is necessary to announce the policy that we will follow concerning accessibility of mass transit for elderly and handicapped in the period before the introduction of Transbus. I have decided that our existing policy in this matter should be continued.

That policy is based on requirements that all manufacturers offer optional equipment (e.g., lifts) for loading wheelchair-bound and other handicapped passengers, and that local transit authorities must either purchase accessible buses, or provide special services suitable for transporting elderly and handicapped passengers.

Many handicapped passengers have expressed concern about the operation and safety of the lift. Additionally, the lifts are cumbersome and time consuming to operate and will become entirely outmoded by the Transbus ramp. They do, however, make buses accessible to mobility-impaired passengers. On the other hand, many elderly and handicapped representatives oppose special services since they require advance notification or have other disadvantages not associated with regular scheduled bus service. These representatives argue that "separate but equal" transit services are inherently unequal and do not enable elderly and handicapped persons to lead the most fully integrated lives possible.

Accordingly, I believe it appropriate to allow local governments to decide how best to serve their elderly and handicapped populations until Transbus is ready for production. Those who purchase lift-equipped buses will thereby offer substantially enhanced accessibility to their elderly and handicapped citizens. Those offering special

services will provide valuable experience for the period after Transbus is introduced since even fully accessible fixed route buses will not meet the transportation needs of all elderly and handicapped. DOT will carefully monitor the activities of grantees of UMTA funds to be certain that the transportation needs of elderly and handicapped citizens are being addressed.

THE TECHNOLOGICAL FEASIBILITY OF TRANSBUS

A critical factor in determining the desirability of a Federal mandate of Transbus is technological and economic feasibility. I find that a bus that meets the existing Transbus specifications, as modified to require a ramp, serves the needs of the elderly and handicapped, can be produced in a reasonable period of time and would be operationally acceptable.

Axles, tires and brakes are the most unique components of the Transbus. These components do not require technological breakthroughs, but merely enough time for proper development. The Transbus prototypes, manufactured by AM General, General Motors and Flxible, showed that in at least one instance the new axles were lightweight, used many existing internal subcomponents and can accommodate the current design automatic transmission.

Similarly, Transbus will probably require tires which are substantially smaller than those presently available. Such tires have been undergoing development for some time and could be put into production in time for Transbus deliveries. While I understand that these tires will have shorter lives than current tires, estimates of Transbus operating costs, as discussed later, include an assumption that the smaller tires will be used. In my view, any problems that the tires may cause are more than offset by the greater accessibility of the Transbus.

Transbus brakes will also be somewhat different than existing bus brakes, yet will utilize essentially the same technology. Despite the smaller diameter wheels, the Transbus specification provides for more brake area per pound of vehicle weight than on current buses. Since this specification can be met using conventional drum brakes, very little development will be required.

Several Transbus operating issues have arisen. These include road clearance, problems associated with the kneeling feature and the appropriate width of the front door. Because the Transbus prototypes experienced minor road clearance problems, the final Transbus specifications require additional road clearance. After the prototypes were tested, every observed ground clearance problem was carefully analyzed and the final specifications written so as to eliminate those problems within the limits of the prototype technology. The specifications call for road clearance equivalent to or better than that attained by all three current model buses.

Some problems have been experienced in the past with the kneeling feature found on ADB's, some current buses and Transbus. First, the earliest kneeling devices did not always operate properly. This was found to be a result of corrosion within electrical components. When greater protection for that system was provided, the problem was solved. Further, there were complaints of drivers not kneeling the bus when passengers needed it. While this remains a potential problem, it

can be overcome by proper driver training. A bus that can kneel to at least 18 inches will benefit all passengers, not just those who need the ramp. These benefits far outweigh the difficulties.

The front door width called for in the specifications is 44 inches. This is wide enough to allow room for wheelchair-bound passengers or to allow for a double stream of ambulatory passengers. This feature is desired by many operators because it allows an inbound and outbound stream at the same time, thus shortening the loading and unloading time. Some operators prefer a narrow (24″) door making a double stream impossible and, therefore, fares easier to collect. The productivity improvements stemming from the wide door and consequent reduced loading time should more than offset any occasional inconvenience in fare collection, and the wide door is a prerequisite to achieving accessibility. For these reasons, the narrow door option has been dropped from the specifications.

The record of the public hearing and studies done for UMTA demonstrate the efficacy of the ramp in providing access for those with mobility impairments. The Transbus specifications call for a ramp that will yield the full benefit of this technology. The specifications provide that the maximum ramp angle on a level street with no curb must not be more than 14 degrees. This means that on a level street with a 6-inch curb, the ramp angle will be less than 10 degrees; even with a typical crowned street and no curb, the ramp angle would be approximately 15 degrees. This is within the range in which most wheelchair-bound persons can be expected to make unassisted entry although in some cases those in wheelchairs may need assistance in exiting. These angles can be accommodated with a ramp not more than 6 feet long and a slight incline where the ramp meets the bus floor. This type of technology has already been utilized by at least one of the prototype manufacturers.

Probably the most complex feasibility questions with respect to Transbus involve its economic viability. The Transbus prototypes included spacious seating arrangements with seating capacity for 42 to 43 people as compared to the maximum seating capacity of current production buses of 51 to 53. Actually, Transbus could have a seating capacity of 47 if it is designed with that goal in mind. ADB's seat between 43–47 passengers, depending on their seat design. Therefore, I do not believe that there will be a serious loss of seating capacity. Moreover, full load capacity is more relevant in determining transit system revenues, and Transbus will have a full load capacity comparable to current buses.

A similar situation exists with regard to weight and fuel economy. The Transbus specifications require that curb weight not exceed 26,000 pounds. This weight is about 1,000 to 2,000 pounds more than current production buses but is the same as the ADB specifications. The added weight is a reflection of the need for an additional axle and related components. Transbus reliability and maintainability have become issues as a result of the greater complexity of Transbus prototypes, especially as compared to current buses. The low floor of the Transbus necessitates greater mechanical complexity in the running gear of the bus, but does not necessitate new or unique technology. It is important to remember that there has been no significant change in bus design in almost 20 years. It is not surprising, therefore, that those with responsibility for maintaining buses are concerned. Experience and

familiarity with these changes and good product design will remedy this problem. I am, therefore, convinced that bus maintainability and reliability will not be seriously affected. Above the floor, Transbus will be similar to ADB's. We will have had considerable experience with ADB's before Transbuses are actually on the street.

Because of its greater complexity, smaller diameter tires and slightly increased weight, the Transbus will cost more than the current bus. The most reliable cost estimates indicate that, while the initial cost of Transbus will be approximately 15 to 18 percent more than current buses, this is only about 5 percent more than ADB's. A comprehensive analysis of cost estimates showed that the Transbus would have operating costs only about one percent higher than current buses. I conclude that these added costs are not unreasonable in light of the substantial benefits to all bus riders which Transbus will provide.

BROCK ADAMS,
Secretary of Transportation.

ITEM 3. LETTER FROM SENATOR FRANK CHURCH, CHAIRMAN, AND SENATOR PETE V. DOMENICI, RANKING MINORITY MEMBER, SENATE SPECIAL COMMITTEE ON AGING, TO HON. BROCK ADAMS, SECRETARY, DEPARTMENT OF TRANSPORTATION, DATED FEBRUARY 15, 1978, AND REPLY DATED APRIL 11, 1978

DEAR MR. SECRETARY: We are writing to seek a clarification of the effect of President Carter's proposal for the improvement of Federal highway and transportation programs, as embodied in S. 2440 and S. 2441, upon transportation services for older Americans in both urban and rural locales. Your responses to the following preliminary questions will greatly assist this Committee in assuring that the Nation's elderly are served by adequate, accessible, and affordable transit services:

—To what extent will new public transportation services funded under the "small urban and rural formula grant program" utilize the experience and findings of demonstration projects funded under the old section 147 Rural Highway program? What improvements in the quality and availability of transportation services for the rural elderly can be expected under the proposed legislation?

—How is the repeal of the 2 percent set-aside for grants for special transportation, under section 16(b)(2) of the Urban Mass Transportation Act, expected to affect the funding level for such activities? While we are aware that this is a permissive rather than a mandatory reserve of funds, the full funding authorization has been utilized during the existence of the program.

—Will assistance for operating expenses now be available to transportation service providers receiving funding under section 16(b)(2)? Will any such assistance be adequate to alleviate the threat caused to many such programs due to the rising costs of vehicle maintenance and insurance?

—Will the new planning requirements set by the proposed bills be utilized to address the problems of duplication and fragmentation which currently exist in special transportation programs receiving assistance from DOT and other Federal sources? What

role does DOT envision for such special transportation programs during the period in which existing mass transit providers transform their bus fleets to accessible vehicles in accord with your "Transbus" decision of last May; and after all such bus fleets are fully accessible?

—Will the nondiscrimination provisions of section 19 of S. 2441 apply to the access of elderly persons to programs funded under the small urban and rural provisions of S. 2440? If not, please provide your rationale.

—In regard to section 102(b)(2) of S. 2441, we would suggest that the language be expanded to make it clear that public transportation services must be operated in a manner which provides services which may be effectively utilized by all citizens; and that the term "transportation disadvantaged" be defined elsewhere in the bill.

May we say that, while we have not yet reviewed all provisions of these bills, we are in accord with the President's goal of establishing a more uniform and coordinated system of Federal transportation assistance. In addition, we applaud your own personal commitment to equal transit rights for the elderly and handicapped, as evidenced in the "Transbus" decision. The nondiscrimination section of S. 2441, by including "age" as an invalid ground for denial of public transit benefits, is a welcome statutory embodiment of this principle.

With best wishes,

Sincerely,

FRANK CHURCH,
Chairman.
PETE V. DOMENICI,
Ranking Minority Member.

THE SECRETARY OF TRANSPORTATION,
Washington, D.C., April 11, 1978.

Hon. FRANK CHURCH,
Chairman, Special Committee on Aging,
U.S. Senate,
Washington, D.C.

DEAR FRANK: Enclosed is the Department of Transportation's response to your recent letter to me on behalf of the Special Committee on Aging, which set forth six questions regarding the effect of the Administration's proposal for the improvement of Federal highway and transportation programs (S. 2440 and S. 2441) upon transportation for older Americans.

Please let me know if we can be of further assistance on this matter.

Sincerely,

BROCK ADAMS.

[Enclosure.]

RESPONSE TO QUESTIONS RE THE EFFECTS OF THE PRESIDENT'S PROPOSAL FOR THE IMPROVEMENT OF FEDERAL HIGHWAY AND TRANSPORTATION PROGRAMS UPON TRANSPORTATION SERVICES FOR OLDER AMERICANS

(1) *Question:* To what extent will new public transportation services funded under the "small urban and rural formula grant program" utilize the experience and findings of demonstration projects funded

under the old section 147 rural highway program? What improvements in the quality and availability of transportation services for the rural elderly can be expected under the proposed legislation?

Response: The Department of Transportation views the section 147 program as a proving ground for what might work in rural and small urban areas to enhance public transportation.

The Department is presently funding approximately 100 demonstration projects in 48 States that encompass a wide variety of types of services and service levels, under varying climates and geographical conditions. The Department expects that these demonstration programs will: (a) develop parameters of what reliability and costs local governments can expect from their rural transit providers; (2) provide data that the Department can use in developing regulations for use in monitoring performance at the local level without burdening grantees with excessive redtape; and (3) develop models for coordination of funds and services as a means of improving the quality and quantity of transportation services.

The Department expects to make available the experience and findings of the ongoing rural highway public transportation demonstration program to all State and local transportation agencies and special service providers at the completion of the program. This information will assist them in designing and operating public transportation programs that can best meet local needs. Currently, as an integral part of the demonstration program, annual regional workshops are held to exchange information among operators and sponsors. These workshops are advancing the state-of-the-art in this developing transportation field.

The elderly can expect at least four improvements in the quality and availability of transportation services:

—There will be more rural service for everyone because of the new sources of funding for rural and small urban transportation. Under the proposed small urban and rural (SUR) transportation assistance program, each state may decide the amount of its apportionment to spend on public transportation, provided that at least 10 percent is dedicated to these projects. Thus, a state could conceivably spend its total SUR apportionment on public transportation, which far exceeds the amount of funds available under the demonstration program. Also, the formula would assure that funds would be distributed more evenly among the States. Since more public transportation projects could potentially be advanced under the legislative proposals, the opportunities for the elderly to travel will likely be enhanced.

—The public transportation services provided will have to incorporate special efforts in the planning and design of the systems so that they can be used effectively by elderly persons.

—The section 147 demonstration program should provide data which planners can use to minimize the delays in starting new services.

—The new legislation will enable providers of transportation services to expand on the successes of the section 147 demonstration program.

(2) *Question:* How is the repeal of the 2 percent set-aside for grants for special transportation, under section 16(b)(2) of the Urban Mass Transportation Act, expected to affect the funding level for such activi-

ties? While we are aware that this is a permissive rather than a mandatory reserve of funds, the full funding authorization has been utilized during the existence of the program.

Response: Although the administration's proposal does not include statutory language describing a section 16(b)(2) permissive set-aside, it is the intention of this administration to strongly encourage States and local areas to use section 5 funds for section 16(b)(2) programs. We believe that at least as much money will be spent under our proposal as is currently utilized under the administrative set-aside.

(3) *Question:* Will assistance for operating expenses now be available to transportation service providers receiving funding under section 16(b)(2)? Will any such assistance be adequate to alleviate the threat caused to many such programs due to the rising costs of vehicle maintenance and insurance?

Response: Although the Department does not anticipate expanding the scope of section 16(b)(2) itself to include assistance for operating expenses, there are other mechanisms for private nonprofit corporations to receive operating funds. In addition to farebox revenues, contract services, and grants from social service agencies, 16(b)(2) operators in urbanized areas can receive operating funds from the public agency that is the recipient of section 5 funds. In rural and small urban areas, the State can provide operating funds directly to 16(b)(2) operators under the language proposed in section 133(f).

(4) *Question:* Will the new planning requirements set by the proposed bills be utilized to address the problems of duplication and fragmentation which currently exist in special transportation programs receiving assistance from DOT and other Federal sources? What role does DOT envision for such special transportation programs during the period in which existing mass transit providers transform their bus fleets to accessible vehicles in accord with your "Transbus" decision of last May, and after all such bus fleets are fully accessible?

Response: One of the most obvious ways to decrease the cost of special transportation programs is to eliminate the duplication and fragmentation of the providers of service. This has been a thrust of the Department's Urban Mass Transportation Administration (UMTA) for several years. It is showing results in places such as Delaware, where a single state agency is the recipient of UMTA and HEW funds for specialized transportation services. In Portland, Oregon, the transit authority is serving as the provider of special transportation programs, and social service agencies are contracting with it for client services. Language in regulations issued by the Department, which require that the planning "process shall consider all modes of transportation", will reinforce, enhance and expand such activities throughout the country.

(5) *Question:* Will the nondiscrimination provisions of section 19 of S. 2441 apply to the access of elderly persons to programs funded under the small urban and rural provisions of S. 2440? If not, please provide your rationale.

Response: Yes. Current highway program directives require that public mass transportation facilities and services be planned, designed, constructed, and operated to allow effective utilization by elderly or handicapped persons. This requirement will remain in force.

(6) *Question:* In regard to section 102(b)(2) of S. 2441, we would suggest that the language be expanded to make it clear that public transportation services must be operated in a manner which provides services which may be effectively utilized by all citizens; and that the term "transportation disadvantaged" be defined elsewhere in the bill.

Response: We do not believe it is necessary to define the term "transportation disadvantaged" because it is not used to create a separate category of individuals for Federal assistance.

We believe the current language, coupled with the language of section 16(a) and section 504 of the Rehabilitation Act of 1973, combine to express adequately the concept embodied in your suggestion.

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Supplement 2

MATERIAL RELATING TO CRIME AND THE ELDERLY

NATIONAL COUNCIL OF SENIOR CITIZENS, INC.,
Washington, D.C., February 15, 1978.

Hon. JAMES O. EASTLAND,
U.S. Senate, Washington, D.C.

DEAR SENATOR EASTLAND: On behalf of the National Committee on Crime and the Elderly, I am contacting you to present the committee's views on S. 551, (also known as the Humphrey-Kennedy bill) which is currently under consideration by the Subcommittee on Criminal Laws and Procedures of the Senate Judiciary Committee. We wish to endorse certain provisions of this bill and to propose certain amendments to it in order to increase its effectiveness in providing assistance to victims of crime.

The National Committee on Crime and the Elderly is composed of all the major organizations representing the interests of older persons in the United States, and, in addition, has had the input of experts in criminal justice and law enforcement.

Formed in 1974 in order to plan and develop a national program of crime prevention and assistance to elderly crime victims, the membership includes the urban elderly coalition, the National Council of Senior Citizens, the National Retired Teachers Association/American Association of Retired Persons, the National Center on the Black Aged, the National Council on Aging and the U.S. Conference on Mayors. Mr. Tony Maggiore of Milwaukee is the committee chairman.

The National Council of Senior Citizens, with whom I am associated, is the national coordinator and research arm of the committee.

Four Federal agencies and the Ford Foundation are supplying financial support for the committee's activities, which consist of demonstration projects in Los Angeles, Chicago, Milwaukee, Washington, New York, and New Orleans. The major local program support comes from the Administration on Aging in HEW and the Community Services Administration.

LEAA is funding the national administrative and coordinating costs as well as research on how the criminal justice system impacts the elderly. HUD is funding a major evaluation of the local operating programs, with emphasis on crime and housing.

As a general proposition, we are not suggesting that benefits or advantages be added only for older persons. We believe that all victims of crime should be treated equally.

It may be, however, that where added costs are thought to be significant, that those victims deemed eligible should be limited to certain groups whose need is greatest.

There are three specific recommendations that we submit should be incorporated as amendments to S. 551.

(1) We recommend an amendment which would require a State to establish a simplified mechanism for any compensation of losses under $100 in order to be eligible for Federal compensation of such losses. This requirement would allow States to eliminate their minimum loss requirement without substantially increasing the administrative costs of their program.

(2) We recommend that the bill be amended to include a provision permitting compensation for the loss of property essential to the well-being and security of the individual. Eligibility for property compensation, if thought fiscally necessary, could be limited to those persons 62 years and older, up to a limit of $1,000.

(3) We recommend that the bill be amended to require a State program to offer emergency assistance to victims of crime in order to qualify for Federal funds.

S. 551 is similar in major respects to H.R. 7010, sponsored by Congressman Rodino which passed the House on September 30, 1977.

However, there are several provisions of S. 551 which differ from the victim compensation bill passed by the House and which we would like to endorse as being of critical importance to a Federal victim compensation law.

(1) We strongly endorse the absence in S. 551 of a requirement for a minimum loss from a crime in order to receive Federal assistance. The House-passed bill, on the other hand, excludes Federal assistance for awards of less than $100 or for lost earnings computed on the basis of less than 5 work days.

(2) We urge that the Federal contribution toward States' costs of paying compensation for qualifying crimes be kept at the 50 percent level provided for in the Humphrey bill rather than at the 25 percent level contained in the House-passed legislation.

(3) We recommend that the ceiling on State awards eligible for Federal grants be kept at the level of $50,000 which is contained in S. 551 rather than at the $25,000 level of the House bill.

Our arguments for the three amendments and three endorsements follow:

AMENDMENTS

1. Simplified Mechanism for Small Claims

S. 551 as presently written does not establish the requirement for a minimum loss from a crime in order to receive Federal assistance. The Rodino bill, as well as most existing State victim compensation programs, contain a minimum loss requirement for the purpose of discouraging nuisance claims and reducing administrative costs which often exceed the cost of providing such benefits. However, our research and the research by the House Select Committee on Aging* have adequately documented that this requirement is detrimental to the interests of elderly and other victims for whom a small loss is a serious hardship. (For further justification, see below: Endorsement: Minimum Loss Requirements).

In order to allow for these small awards for those truly in need without substantially increasing the costs of a State's program, there should be amendment to the act that a State, to be eligible for compensation for small awards, must establish a simplified mechanism

* "In Search of Security: A National Perspective on Elderly Crime Victimization", committee publication No. 95-87, 1977, p. 82.

for any compensation of losses under $100. The law should not specify the manner in which this should be accomplished so as not to infringe on state prerogatives.

2. Compensation for the Loss of Essential Property

A critical issue affecting elderly victims of crime has been omitted from both the Humphrey and Rodino bills and is also excluded from most existing State compensation programs. This is a provision for compensation for property loss. We believe that a Federal victim compensation law should permit compensation for the loss of property essential to the well-being and security of individuals. Property losses can have a devastating impact on all victims and particularly the elderly. The Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging recognized this and recommended that persons 62 years or older with taxable incomes of $3,380 a year or less ($6,076 for a couple) be compensated for the loss of essential property up to a maximum of $1,000. (Select committee report at p. 82.) Only property considered necessary to the well-being and security of the individual would be eligible for reimbursement. Examples of essential items are to include but not be limited to stoves, refrigerators, health support equipment, radios, and televisions.

We recognize the difficulties caused by including property loss under coverage of the Victims of Crime Act. There will be a slight escalation of costs and corresponding depletion of limited resources, but we strongly believe that the problem is serious enough to merit inclusion. Critics of allowing property loss recovery raise two additional reasons which we find weak. First, it is argued by some that since there are limited resources available only the most compelling injuries should be compensated and therefore presume property losses to be of less serious nature. Yet property loss often involves the loss of food, clothing, and housing. Why force victims of crimes to have only their medical cares treated while the equally serious problems of nutrition, housing, and warmth are ignored? Forcing such a choice is an insensitive and illogical solution to a fiscal problem of minor scale.

A second reason frequently stated for exclusion of property loss is that private insurance is often available to cover these losses. This sentiment ignores the fact that most victims of crime are not only without financial resources to replace lost items or cash, but also that they are among the least likely to be protected by insurance. A recent study by the center for criminal justice social policy at Marquette University revealed that while nearly two-thirds of the population are likely to have some insurance protection, the remaining one-third, who are largely from the low-income population most frequently victimized, do not. These were also found to be the persons most commonly victimized by violent crime. The urban elderly are disproportionately represented within this group. (Committee publication No. 95–94, p. 11.)

Because of the serious nature of property losses, we urge that S. 551 be amended to allow States to include awards for compensation of property essential to the well-being and security of the victim in the costs that qualify for Federal funds. This amendment should provide sufficient incentive for States to begin to provide compensation for property loss. If fiscal consideration dictates that eligibility

for property compensation must be limited, we suggest that eligibility be restricted to persons 62 years of age and older, with a maximum limit of $1,000 in compensation.

3. Emergency Funding

Another issue excluded from both bills is the establishment of emergency assistance funds expeditiously administered. Research conducted by our own staff as well as the findings of the Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging disclosed a need for emergency funds for elderly victims based on the limited income and minimal resources available to nearly half of the elderly population. The subcommittee recommended that emergency assistance be provided for such items as food, medicine, rent, utilities, and other essentials. (Select committee report, p. 81.) Our own findings indicated that even in States such as California where the victim compensation program serves as a model for other jurisdictions, it frequently takes 6 months to a year before a victim will be able to receive the needed compensation. Obviously, such compensation is much more critical at the time of the victimization rather than 6 months later when most of the immediate crises have somehow been resolved.

An earlier House bill sponsored by Congressman Roybal (H.R. 6607) included provision for emergency compensation as an essential step in helping victims bridge this administrative gap between the time of filing a claim and the final award. Two additional pieces of relevant legislation have also included emergency compensation plans for victims of crime. One is the late Senator McClellan's S. 1437 which focuses upon victims of Federal crimes and has been reported out of the Senate Judiciary Committee. The second is the Uniform Reparations Act adopted by the National Conference of Commissioners on Uniform States Laws which provides for an emergency compensation. Section 4112(e) of S. 1437 provides:

> If, prior to taking final action upon a claim, the board determines that such claim is one with respect to which compensation will probably be ordered to be paid, the board may order emergency compensation to be paid, not to exceed $1,500, pending final action on the claim. The amount of any emergency compensation ordered and paid shall be deducted from the amount of any final order for compensation. If the amount of any emergency compensation ordered and paid exceeds the amount of the final order for compensation, or if no final order for compensation is made, the claimant may be ordered to make reimbursements to the fund of the difference between such amounts.

Under that proposal, compensation would be available for all appropriate and reasonable medical expenses and services, as well as loss of earnings, but no funds would be provided for food, rent, utilities, or other such items (section 4115).

The Uniform Crime Reparations Act contains a similar provision. Section 15 of the act provides:

> If the board determines that the claimant would suffer financial hardship unless a tentative award is made, and it

appears that a final award will be made, an amount may be paid to the claimant, to be deducted from the final award or repaid by and recoverable from the claimant to the extent that it exceeds the final award.

Neither of these approaches should increase the cost of a State compensation program because the amount of any interim or emergency award is to be deducted from the final award. Moreover, emergency compensation is compatible with the principle of "federalism" because it does not affect in any way the scope of coverage pursuant to a State program. The provision does nothing more than permit funds to be advanced on an award that would have been made in any event. Emergency compensation may slightly increase the costs of administration, but the benefits far outweigh the added costs. Thus, we are recommending that one of the requirements for a State to qualify for Federal funding through the Criminal Victim Act of 1977 be that it must provide some form of emergency compensation.

ENDORSEMENTS

1. Minimum Loss Requirement

A conflict between the Rodino and Humphrey bills involves the presence of a minimum loss requirement. The Rodino bill excludes Federal payments for awards of less than $100 or for lost earnings computed on the basis of less than 5 working days. The Humphrey bill does not include a minimum loss requirement. We strongly favor the Humphrey bill's position as in the best interests of the elderly crime victim.

With 43.8 percent of elderly couples at or below the poverty level, it is readily apparent that it is extremely difficult, if not impossible, for them to recoup monetary losses. The select committee report suggested that no minimum loss be established as a requirement for assistance "due to the relative and absolute poverty of many of the elderly crime victims." (Select committee report at p. 82.) As that report points out, even the loss of $20 can represent a much greater relative loss to the older person on a small, fixed income. This amount of money can deny food or essential drugs, or cause a utility bill to go unpaid.

We endorse S. 551 which, by deleting this minimum loss requirement, will encourage States to reexamine their legislation to determine if they too should delete the minimum loss requirement. For those States which do decide to change their programs, the amendment suggested above (see Amendments: Simplified Mechanism for Small Claims) will assure that administrative costs for such claims do not become prohibitive.

2. Federal Contribution of 50 Percent of State Costs

The Rodino bill and S. 551 differ in the amount which the Federal Government will contribute to the States toward their costs for compensating victims of eligible State crimes. The Rodino bill would offer 25 percent while S. 551 would pay 50 percent of State costs. We endorse the larger Federal contribution included in S. 551 since it would serve as a mechanism for inducing more States to establish

victim compensation programs. Only 24 States presently operate victim compensation programs. Therefore, more than half of the States are anxiously looking to the Congress to see if they should establish such a program. Obviously, the larger the Federal contribution, the greater chance that other States will establish a victim compensation program. Therefore, the Rodino bill which requires that a State pay for three-fourths of the claims would provide less of an incentive for those States contemplating the adoption of compensation programs.

3. Maximum Level of $50,000 Award for Crime Victims

Another area of conflict between the Rodino bill and S. 551 is the maximum amount of State award which would be eligible for Federal compensation. The Rodino bill sets this amount at not to exceed $25,000 while the Humphrey bill sets the upward limit at $50,000. We endorse the $50,000 figure proposed in S. 551. Given present inflationary costs for daily subsistence as well as the astronomical expense of medical care, it is important that this maximum limit provide a realistic opportunity for victims of crime to be made whole. The necessity for maintaining at least the $50,000 maximum is crucial from the perspective of the elderly, who can be expected to have more serious problems while also being least able financially to have alternative sources of income to draw from. Studies have shown that the elderly, particularly those living in urban settings where most of the victimization occurs, are least likely to have insurance, and most likely to be receiving a fixed income, existing on or below the poverty line.

It is hoped that our comments will be seriously considered. The problems of elderly victims of crime, as well as victims of all ages, is an important issue. We applaud the initial steps taken by this Congress to produce a Victim of Crime Act that will be meaningful to Americans of all ages.

Sincerely,

DAVID H. MARLIN,
Director, Legal Research and Services for the Elderly.

Supplement 3

MATERIAL RELATED TO HOUSING

LETTER FROM SENATOR FRANK CHURCH TO JOSEPH G. ANASTASI, SECRETARY, DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT, MARYLAND HOUSING REHABILITATION PROGRAM, DATED NOVEMBER 22, 1977, AND REPLY DATED DECEMBER 2, 1977

DEAR MR. ANASTASI: The August 1977 issue of the Maryland Office on Aging's "Outlook" newsletter has brought your new program of low-interest rehabilitation loans to this committee's attention.

Because of the success which such programs seem to be having in other locales, and due to our interest in approaches which can assist older homeowners in remaining in and improving their homes, I would greatly appreciate further information about this program. An appraisal of how it will assist older homeowners in insulating their dwellings would be particularly helpful.

This information will help the committee in formulating new approaches to assisting older Americans.

Thanking you in advance, I am

Sincerely,

FRANK CHURCH, *Chairman.*

DEAR SENATOR CHURCH: I was pleased to receive your letter of November 22 inquiring about our newly implemented Maryland housing rehabilitation program. We are very excited about the potential of this program despite its initially small funding level of $2 million.

As you can see from the enclosed information, the program operates through local governments so special needs in a community, such as those of elderly homeowners, can be addressed. Also, since it is not necessary under this program for all code deficiencies of a structure to be corrected, it will be possible to use the program for special purposes such as weatherization. We also feel it allows sufficient administrative flexibility to work in tandem with other types of programs such as the ones which utility companies may be initiating under new Federal energy legislation.

This program is administered by a division of this department, the Community Development Administration (CDA), which is the housing finance agency in Maryland. By copy of this letter, I am bringing your inquiry to the attention of Thomas M. Cook, CDA director. If you desire any further information on this program, please contact him or a member of his staff directly. We would be more than happy to meet with you or your staff concerning this unique program which, to our knowledge, is the first of its kind administered by a State agency.

Sincerely,

JOSEPH G. ANASTASI.

[Enclosure.]

Local Government Participation in MHRP

The Department of Economic and Community Development recognizes that the most effective housing rehabilitation programs are those administered at the local level. Therefore, the program will encourage each political subdivision in the State to develop the capacity to originate and administer MHRP loans. Many subdivisions do not now have this capacity and will need time to develop it.

The program staff will provide varying degrees of technical assistance to those subdivisions which demonstrate an interest in the program until they are able to administer it themselves. Training will be offered to local personnel participating in the program and each subdivision will be encouraged to gradually expand its role. A political subdivision might ultimately choose to hire consultants to administer rehabilitation loans, share technical and administrative staff with other subdivisions or use their own staff. Any of these approaches or combinations of them could be used to administer MHRP loans.

Allocation of Funds

The Maryland housing rehabilitation program obtains its funds from periodic sales of State general obligation bonds. The funds from a bond sale are initially allocated among the counties of Maryland on a formula basis. The program informs each county of its initial allocation when it becomes available. A county has 30 days to formally indicate whether or not it intends to use its allocation. Some or all of a county's allocation may be suballocated to political subdivisions within a county. This suballocation may occur at a county's initiative or if a county chooses not to participate.

Every political subdivision, whether county or municipality, which participates in the program must file a rehabilitation plan for the use of its allocation. The initial allocation may be modified in light of a subdivision's capacity to utilize funds or expressed in its rehabilitation plan, cooperative arrangements for use of funds or other relevant information.

The Rehabilitation Plan

A rehabilitation plan is required from each political subdivision which wants to participate in the program. Rehabilitation loans will not be made without the participation of a local unit of government. The rehabilitation plan has two main parts. In the first, a political subdivision describes its capacity to administer a rehabilitation program and defines its role in the program. In the second part, each subdivision defines a rehabilitation loan program, which is geared to its own priorities and local conditions.

MHRP is intended to complement existing local, State and Federal programs and allows a number of options which can be used to develop a comprehensive local program in conjucntion with other funding sources. In the second part of the rehabilitation plan each political subdivision defines a target area in which loans will be made from its allocation and chooses income limits, loan sizes, and other options which suit its individual needs.

The requirements of the entire rehabilitation plan are described below. These requirements are still in draft form and subject to revision.

PART 1—LOCAL CAPABILITIES AND LOAN ADMINISTRATION

A political subdivision wishing to participate in the program may choose to originate and administer loans from its allocation or work jointly with State officials to originate and administer such loans. If a political subdivision wishes to originate and administer loans it must satisfy the provisions of section A, below, and document this in its rehabilitation plan. If a political subdivision wishes to work together with State officials it must satisfy the requirements of part B.

A. Self Administration

(1) The political subdivision must hire the minimum staff necessary to adequately administer the program, which shall include:

(a) A rehabilitation director experienced in operating a rehabilitation program, supervising employees and dealing with the public;

(b) a rehabilitation specialist/cost estimator experienced in residential rehabilitation, cost estimating, writing specifications and blue print reading;

(c) a building/housing inspector experienced in residential inspections and trained to understand and apply the appropriate codes and rehabilitation standards;

(d) a financial advisor experienced in mortgage lending and financial processing of loans; and

(e) clerical and administrative staff trained to ensure prompt and efficient processing of applications, draw schedules and other required items.

(2) The rehabilitation staff of the political subdivision must, in addition, be capable of:

(a) Determining local rehabilitation needs, evidenced by completion of a housing assistance plan, local comprehensive plan, or a local housing plan;

(b) estabilshing a rehabilitation program, evidenced by prior experience in the development and operation of a rehabilitation program;

(c) evaluating loan applications, and monitoring both the loans and the work done under those loans, evidenced by the successful performance of performance of these functions for at least 9 months prior to certification.

B. Joint Administration

(1) The department will continue to provide varying degrees of administrative and technical assistance provided that the political subdivision has demonstrated its interest and commitment by:

(a) Identifying a staff person capable of and responsible for local administration of the loans;

(b) identifying what assistance the political subdivision is capable and willing to provide to eligible borrowers under the program and what services it wishes the State Program staff to provide; and

(c) identifying the steps the political subdivision will take, consistent with its administrative and financial capacity, to become more self-sufficient in the origination and administration of State rehabilitation funds.

PART 2—DEFINING A LOCAL PROGRAM

Each participating political subdivision needs to define its rehabilitation loan program by:

(A) Identification on a map of the target area within which loans from the allocation will be made. The target area may be a community (neighborhood), small town (under 10,000 population), or a defined part of a county. The target area should be selected with reference to the income limits and loan size which the political subdivision selects. Within the target area there should be a sufficient number of "eligible borrowers" who are interested in and can afford rehabilitation loans and a sufficient number of "eligible properties."

(B) Information on the target area including:

(1) A description of the housing conditions;

(2) general social and economic characteristics; and

(3) identification of public improvements or services recently implemented or planned in the area.

(C) Local policies for use of funds under the allocation including:

(1) Income limits for "limited income families" and "limited income tenants" which may be set at or below the maximum amounts established in these regulations;

(2) maximum loan amounts which may be established at or below the maximum amounts established in these regulations;

(3) a policy on conversions which will allow no conversions or encourage either higher densities or lower densities in the target area;

(4) a maximum percent of the funds that will be used for rehabilitation of historic properties where the income of the borrower exceeds the income limits; and

(5) a maximum percent of the funds that will be used for rehabilitation of nonresidential properties.

(D) Information on the need for rehabilitation funds in the political subdivision during the next 3 years.

(E) Identification of any local code or rehabilitation standard that will be used in making loans under the program. Any such code or standard must be deemed sufficient by the secretary and a current copy must be on file with the program.

INDEX

Hearings and reports published by this committee are indexed by the following key:

REPORTS

"Developments in Aging: 1977," page numbers are *italic*.

ADE.—"The Next Steps in Combating Age Discrimination in Employment: With Special Reference to Mandatory Retirement Policy," committee print, August 1977.

KMP.—"Kickbacks Among Medicaid Providers," Senate report, June 30, 1977.

OIT.—"Protecting Older Americans Against Overpayment of Income Taxes (A Revised Checklist of Itemized Deductions for Use in Taxable Year 1977)," committee print, December 1977.

PFB.—"The Proposed Fiscal 1978 Budget: What It Means for Older Americans," committee print, March 1977.

PSE.—"Protective Services for the Elderly," committee print, July 1977.

HEARINGS

EFS.—"Effectiveness of Food Stamps for Older Americans," parts 1 and 2, Washington, D.C., April 18 and 19, 1977.

HCA.—"Health Care for Older Americans: The 'Alternatives' Issue," parts 1, 2, and 3, Washington, D.C., May 16, 17, and June 15, 1977; part 4, Cleveland, Ohio, July 6, 1977.

ILR.—"Improving Legal Representation for Older Americans," parts 3 and 4, Washington, D.C., September 28 and 29, 1976.

L-T.—"Trends in Long-Term Care," part 27, New York, N.Y., March 19, 1976.

MAA.—"Medicine and Aging: An Assessment of Opportunities and Neglect," New York, N.Y., October 13, 1976.

MMF.—"Medicare and Medicaid Frauds," parts 5, 6, and 7, Washington, D.C., August 30, 31, and November 17, 1976; parts 8 and 9, Washington, D.C., joint hearings with subcommittees of the House Ways and Means Committee, March 8 and 9, 1977.

NRE.—"The Nation's Rural Elderly," part 1, Winterset, Iowa, August 16, 1976; part 2, Ottumwa, Iowa, August 16, 1976; part 3, Gretna, Nebr., August 17, 1976; part 4, Ida Grove, Iowa, August 17, 1976; part 5, Sioux Falls, S. Dak., August 18, 1976; part 6, Rockford, Iowa, August 18, 1976; part 7, Denver, Colo., March 23, 1977.

REC.—"The Impact of Rising Energy Costs on Older Americans," parts 4, 5, and 6, Washington, D.C., April 5, 7, and June 28, 1977.

TrE.—"Transportation and the Elderly: Problems and Progress," part 6, Washington, D.C., July 12, 1977.

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